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CHAPTER 836
DEPARTMENT OF CONSUMER AND BUSINESS SERVICES
INSURANCE REGULATION

FILING CAPTION: Amendment to 2026 standard silver health benefit plan

EFFECTIVE DATE: 07/01/2025

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AMEND: 836-053-0013

RULE TITLE: Oregon Standard Bronze and Silver Health Benefit Plans

NOTICE FILED DATE: 04/24/2025

RULE SUMMARY: Update standard silver plans.

RULE TEXT:
(1) This rule applies to plan years beginning on and after January 1, 2017.
(2) As used in this rule, "coverage" includes medically necessary benefits, services, prescription drugs and medical devices. "Coverage" does not include coinsurance, copayments, deductibles, other cost sharing, provider networks, out-of-network coverage, or administrative functions related to the provision of coverage, such as eligibility and medical necessity determinations.
(3) For purposes of coverage required under this rule:
(a) "Inpatient" includes but is not limited to:
(A) Inpatient surgery;
(B) Intensive care unit, neonatal intensive care unit, maternity and skilled nursing facility services; and
(C) Mental health and substance abuse treatment.
(b) "Outpatient" includes but is not limited to services received from ambulatory surgery centers and physician and anesthesia services and benefits when applicable.
(c) A reference to a specific version of a code or manual, including but not limited to references to ICD-10, CPT, Diagnostic and Statistical Manual of Mental Disorders, (DSM-5), Fifth Edition; place of service and diagnosis includes a reference to a code with equivalent coverage under the most recent version of the code or manual.
(4) When offering a plan required under ORS 743B.130, an insurer must:
(a) Use the following naming convention: "[Name of Insurer] Standard [Bronze/HSA/Silver] Plan." The name of insurer may be shortened to an easily identifiable acronym that is commonly used by the insurer in consumer facing publications.
(b) Include a service area or network identifier in the plan name if the plan is not offered on a statewide basis with a statewide network.
(5) Coverage required under ORS 743B.130 must be provided in accordance with the requirements of sections (6) to

(11) of this rule.
(6) Coverage must be provided in a manner consistent with the requirements of:
(a) 45 CFR 156, except that actuarial substitution of coverage within an essential health benefits category is prohibited;
(b) OAR 836-053-1404, 836-053-1405, 836-053-1407 and 836-053-1408;
(c) The federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act, 29 U.S.C. 1185a and implementing regulations at 45 CFR 146.136 and 147.160; and
(d) For plan years beginning on or after January 1, 2019, Chapter 721, Oregon Laws 2017 (Enrolled House Bill 3391).
(7) Coverage must provide essential health benefits as defined in OAR 836-053-0012.
(8) Except when a specific benefit exclusion applies, or a claim fails to satisfy the insurer's definition of medical necessity or fails to meet other issuer requirements the following coverage must be provided:
(a) Ambulatory services;
(b) Emergency services;
(c) Hospitalization services;
(d) Maternity and newborn services;
(e) Rehabilitation and habilitation services including:
(A) Professional physical therapy services;
(B) Professional occupational therapy;
(C) Physical therapy performed by an occupational therapist; and
(D) Professional speech therapy;
(f) Laboratory services;
(g) All grade A and B United States Preventive Services Task Force preventive services, Bright Futures recommended medical screenings for children, Institute of Medicine recommended women's guidelines, and Advisory Committee on Immunization Practices recommended immunizations for children coverage must be provided without cost share; and
(h)(A) Prescription drug coverage at the greater of:
(i) At least one drug in every United States Pharmacopeia (USP) category and class as the prescription drug coverage of the plan described in OAR 836-053-0012(2); or
(ii) The same number of prescription drugs in each category and class as the prescription drug coverage of the plan described in OAR 836-053-0012(2).
(B) Insurers must submit the formulary drug list for review and approval. The formulary drug list must comply with filing requirements posted on the Department of Consumer and Business Services website.
(C) For plan years beginning on or after January 1, 2017 insurers must use a pharmacy and therapeutics committee that complies with the standards set forth in 45 CFR 156.122.
(9) Copays and coinsurance for coverage required under ORS 743B.130 must comply with the following:
(a) Non-specialist copays apply to physical therapy, speech therapy, occupational therapy and vision services when these services are provided in connection with an office visit.
(b) Subject to the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act, 29 U.S.C. 1185a, specialist copays apply to specialty providers including mental health and substance abuse providers, if and when such providers act in a specialist capacity as determined under the terms of the health benefit plan.
(c) Coinsurance for emergency room coverage must be waived if a patient is admitted, at which time the inpatient coinsurance applies.
(10) Deductibles for coverage required under ORS 743B.130 must comply with the following:
(a) For a bronze plan, in accordance with the coinsurance, copayment and deductible amounts and coverage requirements for a bronze plan set forth in the cost-sharing matrix as adopted in Exhibit 1 to this rule.
(b) For a silver plan, in accordance with the coinsurance, copayment and deductible amounts and coverage requirements for a silver plan set forth in the cost-sharing matrix as adopted in Exhibit 2 to this rule.
(c) The individual deductible applies to all enrollees, and the family deductible applies when multiple family members incur claims.

(11) Dollar limits for coverage required under ORS 743B.130 must comply with the following:
(a) Annual dollar limits must be converted to a non-dollar actuarial equivalent.
(b) Lifetime dollar limits must be converted to a non-dollar actuarial equivalent.

STATUTORY/OTHER AUTHORITY: ORS 731.244, 45 CFR 156.135(g)

STATUTES/OTHER IMPLEMENTED: ORS 743B.130

2026
Standard Silver Plan

Benefit	2025 Standard Silver	2026 Standard Silver
2026 Federal AV	72.71%	71.90%
Deductible	Medical: $5,500 Drug: $0	Medical: $6,100 Drug: $0
Maximum OOP	Combined Medical and Drug $9,200	Combined Medical and Drug $9,200
Family multiplier	2x Individual; Embedded Approach	2x Individual; Embedded Approach
Primary Care Visit to Treat an Injury or Illness	$40(†)	$40(†)
Specialist Visit	$80	$100
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	30% After Deductible	30% After Deductible
Outpatient Surgery Physician/Surgical Services	30% After Deductible	30% After Deductible
Inpatient Hospital Services (e.g., Hospital Stay)	30% After Deductible	30% After Deductible
Inpatient Physician and Surgical Services	30% After Deductible	30% After Deductible
Inpatient Rehabilitation Services	30% After Deductible	30% After Deductible
Inpatient Habilitation Services	30% After Deductible	30% After Deductible
Urgent Care Centers of Facilities	$70	$70
Emergency Room Services	30% After Deductible	30% After Deductible
Generic Drugs	$15**	$15**
Preferred Brand Drugs	$60**	$60**
Non-Preferred Brand Drugs	50%**	50%**
Specialty Drugs	50%**	50%**
Pediatric Vision	Exams at $0 for these codes: 92002/92004, 92012/92014, S0620/S0621; for other codes cost shares may apply. Contact lenses - Actuarial equivalent of $150 per year. Frames - Actuarial equivalent of $150 per year. Lenses at $0 for codes V2100-2299, V2300-2399, V2121, V2221, V2321; for other codes cost shares may apply.	Exams at $0 for these codes: 92002/92004, 92012/92014, S0620/S0621; for other codes cost shares may apply. Contact lenses - Actuarial equivalent of $150 per year. Frames - Actuarial equivalent of $150 per year. Lenses at $0 for codes V2100-2299, V2300-2399, V2121, V2221, V2321; for other codes cost shares may apply.
Outpatient Rehabilitation Services	$40 (Applies to PT,OT, ST provided in an office setting); PT OT, ST provided in emergency room or urgent care setting is subject to applicable co-insurance.	$40 (Applies to PT,OT, ST provided in an office setting); PT OT, ST provided in emergency room or urgent care setting is subject to applicable co-insurance.
Outpatient Habilitation Services	$40 (Applies to PT,OT, ST provided in an office setting); PT OT, ST provided in emergency room or urgent care setting is subject to applicable co-insurance.	$40 (Applies to PT,OT, ST provided in an office setting); PT OT, ST provided in emergency room or urgent care setting is subject to applicable co-insurance.
Biofeedback	$40	$40
Cardiac Rehabilitation	$40	$40
Imaging (CT/PET Scans, MRIs)	30% After Deductible	30% After Deductible
Preventive Benefits *	$0	$0
Diabetes Education	$0	$0
Nutritional Counseling	$0	$0
Diabetic Supplies	$0	$0
Laboratory Outpatient and Professional Services	30% After Deductible	30% After Deductible
X-rays and Diagnostic Imaging	30% After Deductible	30% After Deductible
Acupuncture	$40 - limit 12 visits per year	$40 - limit 12 visits per year
Chiropractic	$40 - limit 20 visits per year	$40 - limit 20 visits per year

* Preventive Benefits include, but are not limited to, services a carrier is required to provide without cost sharing under Oregon Laws 2017, Chapter 721 (HB 3391).

**ORS 743A.069 Limits cost-sharing for health benefit plan coverage of insulin prescribed for treatment of diabetes. SB 1508 amends this to $35 for each 30-day supply and $105 for each 90-day supply.

(†) First three primary care visits must be covered at $5 copayment