Department of Consumer and Business Services
Division of Financial Regulation
350 Winter Street NE
Salem, Oregon 97309
Phone (503) 947-7983

Standard Provisions for Large Group Health Benefit Plans
(Including Self Insured Health Benefit Plans for Public Entities per ORS 731.036(6))

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 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**.**
Filings that do not include required information or policy provisions will result in delays of the filing.

Insurer or public entity name: _____ **Requested effective date:** _____

TOI (type of insurance):
- ☐ H15G Hospital/Surgical/Medical Expense
- ☐ H16G Group Health - Major Medical

Sub-TOI
- ☐ H15G.002 Hospital/Surgical/Medical Expense - Large Group Only

☐ H16G.001A	or	☐ H16G.002A	Group Health – Major Medical - PPO
☐ H16G.001B	or	☐ H16G.002B	Group Health – Major Medical - POS
☐ H16G.001C	or	☐ H16G.002C	Group Health – Major Medical – Other
☐ H16G.001D	or	☐ H16G.002D	Group Health – Major Medical - EPO

Type of carrier: ☐ Health insurer ☐ Health Care Service Contractor ☐ Self-insured entity

Type of plan: ☐ Grandfathered Plans

** Indicates standard does not apply to Health Care Service Contractors per ORS 750.055, but may be subject to federal standard*
^ Indicates standard does not apply to self insured public entities

Forms filed using this document must meet the definition for a health benefit plan per ORS 743B.005(16)

GENERAL REQUIREMENTS (FOR ALL FILINGS)			
Category	Reference	Description of review standards requirements	Answer
Submission package requirements	**SERFF or Oregon Division of Financial Regulation website:** OAR 836-010-0011	http://dfr.oregon.gov/rates-forms/health/Pages/health.aspx These must be submitted for 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 or cover letter	OAR 836-010-0011(4), ORS 731.296	The filing description or 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 similar forms and the new forms. 3. The differences between in-network and out-of-network, if applicable. **Please 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/or certificate. 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.	Yes N/A ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
Clear policy language	ORS 742.005(2)	The Evidence of Coverage must be clear, understandable, and unambiguous.	Yes N/A ☐ ☐

Category	Reference	Description of review standards requirements	Answer
Clear policy language, (continued)	ORS 743.106(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)	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.	Yes ☐ N/A ☐
	ORS 743.106(1)(b)	The font shall be uniform and not less than 12-point type	Yes ☐ N/A ☐
Cover page	ORS 742.005, OAR 836-010-0011	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. 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 the forms. The form number is adequate to distinguish the form from all others used by the insurer. 6. The policy contains a brief caption that appears prominently on the cover page and describes the type of coverage.	Yes ☐ 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(2)	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.	Yes ☐ N/A ☐

Category	Reference	Description of review standards requirements	Answer
Variability in forms, (continued)	ORS 742.003, ORS 742.005(2)	• 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: http://dfr.oregon.gov/rates-forms/health/Pages/health.aspx	
APPLICABILITY			
Category	Reference	Description of review standards requirements	Answer
Applications	Form 440-2442H	If application forms are included in the filing, please also submit Form 440-2442H *Standards for Health Applications*. **Note:** no medical questions are permitted for this product type except for tobacco use and age.	Yes ☐ N/A ☐
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 ☐
Modification and discontinuance	ORS 743B.105	Submit Form 440-2896 *Transmittal and Requirements for Modification and Discontinuance of Health Benefit Plans when making a uniform modification or discontinuing a plan.* **Note:** modifications and discontinuances can be submitted either in this form filing or as a separate filing. Within the filing, please identify which of the following notices will be used: State or Federal.	Yes ☐ N/A ☐
Multiple Employer Welfare Arrangements (MEWA)	ORS 750.301 to 341, OAR 836-053-0007	File under Form 440-2448M *Standard Provisions for Multiple Employer Welfare Arrangements Group Health Benefit Plans*.	
BENEFIT REIMBURSEMENT			
Category	Reference	Description of review standards requirements	Answer
Bilateral cochlear implants	ORS 743A.140, HB 4104(2018)	The plan must cover bilateral cochlear implants if medically appropriate for the treatment of hearing loss.	Confirmed ☐
Clinical trials	ORS 743A.192, 42 USC §300gg–8	The policy and certificate must comply with both Oregon and federal clinical trial mandates.	Confirmed ☐

Category	Reference	Description of review standards requirements	Answer
Colorectal cancer screenings and laboratory tests	ORS 743A.124	A health benefit plan, as defined in ORS 743B.005, shall provide coverage for all colorectal cancer screening examinations and laboratory tests assigned either a grade of A or a grade of B by the United States Preventive Services Task Force. For members aged 50 and older, an insurer may not impose cost sharing on the colorectal cancer screening, examinations and lab tests and must cover, at a minimum: • Fecal occult blood tests (note: colonoscopies following a positive fecal test assigned a grade of A or B by the USPSTF must still be provided without cost sharing) • Colonoscopies, including the removal of polyps during a screening procedure; or • Double contrast barium enemas. If an insured is at high risk for colorectal cancer, the required coverage shall include colorectal cancer screening examinations and laboratory tests as recommended by the treating physician.	Page: Paragraph or Section:
Contraceptives	ORS 743A.066, ORS 743A.067 PHSA 2713 45 CFR 147.130 42 U.S. Code § 300gg–13 HRSA Guidelines	HRSA Guidelines require coverage, without cost sharing, for all Food and Drug Administration (FDA) approved contraceptive methods, sterilization procedures, and patient education and counseling for all women with reproductive capacity, as prescribed by a provider. Plan must reimburse health care provider or dispensing entity for a dispensing of a contraceptive indented to last for: • A three month period for the first dispensing of the contraceptive to an insured. • A twelve month period for subsequent dispensing of the same contraceptive to the insured regardless of whether the insured was enrolled in the program, plan or policy at the time of the first dispensing.	Page: Paragraph or Section:

Category	Reference	Description of review standards requirements	Answer
Contraception prescribed by pharmacists	HB 2879(2015), HB 2527(2017), ORS 743A.066, ORS 689.005, ORS 689.683	Contraceptive benefit allows a pharmacist to prescribe and dispense hormonal contraceptive patches, injectable hormonal contraceptives, and self-administered oral hormonal contraceptives within limits described in HB 2879 and HB 2527. Contraceptive benefit allows a pharmacist to: • Prescribe and dispense hormonal contraceptive patches and self-administered oral hormonal contraceptives within limits described in HB 2879. • Prescribe and administer injectable hormonal contraceptives within the limits prescribed in HB 2527	Page: Paragraph or Section:
Confidential Communication Request	ORS 743B.250, ORS 743B.555	"Confidential communications request" means a request from an enrollee to a carrier or third party administrator that communications be sent directly to the enrollee and that the carrier or third party administrator refrain from sending communications concerning the enrollee to the policyholder or certificate holder. Confidential communication request must be made available to members.	Confirmed ☐
Craniofacial anomaly treatment	ORS 743A.150	A policy shall provide coverage for dental and orthodontic services for the treatment of craniofacial anomalies if the services are medically necessary to restore function.	Confirmed ☐
Diabetes management for pregnant women	ORS 743A.082	A health benefit plan may not require any cost sharing requirements on the covered health services, medications, and supplies that are medically necessary for a woman to manage her diabetes, beginning with conception and ending six weeks postpartum. **Note:** this does not apply to a high deductible health plan described in 26 U.S.C. 223.	Page: Paragraph or Section:

Category	Reference	Description of review standards requirements	Answer
Drug Formularies	OAR 836-053-1020	A plan's formulary must contain an exception process unless the product is using an open formulary. An insurer that uses a closed formulary must have a written procedure stating that FDA approved prescription drug products are covered only if they are listed in the formulary. The procedure must also describe how the insurer determines the content of the closed formulary and how the insurer determines the application of a medical exception. The procedure must describe how a provider may request inclusion of a new item in the closed formulary and must ensure that the insurer will issue a timely written response to a provider making such a request. Such procedures must include a process for an enrollee, the enrollee's designee, or the enrollee's prescribing physician (or other prescriber) to request an expedited review based on exigent circumstances. A health plan must make its coverage determination on an expedited review request based on exigent circumstances and notify the enrollee or the enrollee's designee and the prescribing physician (or other prescriber, as appropriate) of its coverage determination **no later than 24 hours after it receives the request.** An insurer that uses an open formulary must have a written procedure that includes the written criteria or explains the review process established by the insurer for determining when an item will be limited or excluded pursuant to the insurer's policy regarding medical appropriateness. **Open formulary** OAR 836-053-1020(2) An insurer must also disclose that a denial of an exception to a prescription drug formulary entitles an enrollee to review of the decision under the carriers' internal and external appeals process.	Confirmed ☐ N/A ☐
Emergency eye care services	ORS 743A.250	Provides coverage of emergency eye care services without first receiving a referral or prior authorization from a primary care provider	Confirmed ☐

Category	Reference	Description of review standards requirements	Answer
Emergency Services	ORS 743A.012(1)(2), 45 CFR §147.138, HB 3091 (2017)	Health benefit plans shall provide coverage without prior authorization for emergency services. • "Behavioral health assessment" means an evaluation by a behavioral health clinician, in person or using telemedicine, to determine a patient's need for immediate crisis stabilization. • "Behavioral health clinician" means a licensed psychiatrist, psychologist, certified nurse practitioner with a specialty in psychiatric mental health, clinical social worker, professional counselor or licensed marriage and family therapist, certified clinical social work associate, an intern or resident who is working under a board-approved supervisory contract in a clinical mental health field, or any other clinician whose authorized scope of practice includes mental health diagnosis and treatment. • "Behavioral health crisis" means a disruption in an individual's mental or emotional stability or functioning resulting in an urgent need for immediate outpatient treatment in an emergency department or admission to a hospital to prevent a serious deterioration in the individual's mental or physical health • "Emergency medical condition" means a medical condition: o 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: (i) Place the health of a person, or an unborn child in the case of a pregnant woman, in serious jeopardy; (ii) Result in serious impairment to bodily functions; or (iii) Result in serious dysfunction of any bodily organ or part; • With respect to a pregnant woman who is having contractions, for which there is inadequate time to effect a safe transfer to another hospital before delivery or for which a transfer may pose a threat to the health or safety of the woman or the unborn child**;** or • That is a behavioral health crisis. • "Emergency medical screening exam" means the medical history, examination, ancillary tests and medical determinations required to ascertain the nature and extent of an emergency medical condition.	Page: Paragraph or Section:

Category	Reference	Description of review standards requirements	Answer
Emergency Services (continued)	ORS 743A.012(1)(2), 45 CFR §147.138, HB 3091 (2017)	• "Emergency services" means with respect to an emergency medical condition. o An emergency medical screening exam or behavioral health assessment that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition; and (B) Such further medical examination and treatment as are required under 42 U.S.C. 1395dd to stabilize a patient, to the extent the examination and treatment are within the capability of the staff and facilities available at a hospital.	Page: Paragraph or Section:
Emergency services - Nonparticipating providers	ORS 743A.012(3)(b), 45 CFR §147.138	For the services of a nonparticipating provider: A. Without imposing any administrative requirement or limitation on coverage that is more restrictive than requirements or limitations that apply to participating providers; B. Without imposing a copayment amount or coinsurance rate that exceeds the amount or rate for participating providers; C. Without imposing a deductible, unless the deductible applies generally to nonparticipating providers; and D. Subject only to an out-of-pocket maximum that applies to all services from nonparticipating providers.	Confirmed ☐
Emergency services - Information to enrollees	ORS 743A.012(4)(5) ORS 743B.250 OAR 836-053-1030	Health benefit plans shall provide information to enrollees in plain language regarding: a) What constitutes an emergency medical condition; b) The coverage provided for emergency services; c) How and where to obtain emergency services; and d) The appropriate use of 9-1-1. An insurer may not discourage appropriate use of 9-1-1 and may not deny coverage for emergency services solely because 9-1-1 was used.	Page: Paragraph or Section:
Gender Dysphoria	ORS 742.005(4), ORS 746.015(1), ORS 743A.168, OAR 836-053-1404, OAR 836-053-1405, Bulletin 2014-1, Bulletin 2016-1	Gender Dysphoria is a condition defined in the DSM-V and must be covered in compliance with Oregon Bulletin 2016-1 <u>including an affirmative statement of coverage of gender-affirming services in their evidence of coverage documents.</u> Health insurance plans cannot discriminate against people on the basis that the treatment is for gender identity issues.	Page: Paragraph or Section:

Category	Reference	Description of review standards requirements	Answer
Gender Dysphoria	ORS 742.005(4), ORS 746.015(1), ORS 743A.168, OAR 836-053-1404, OAR 836-053-1405, Bulletin 2014-1, 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. 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.	Page: Paragraph or Section:
Gender Specific Contract Language	OAR 836-010-0155	An individual's attending provider determines whether a sex-specific recommended preventive service that is required to be covered without cost sharing under section 2713 of the Public Health Service Act and its implementing regulations is medically appropriate for a particular individual. When an attending provider determines that a recommended service is medically appropriate for an individual and the individual satisfies the criteria for the service or treatment, the insurer must provide coverage for the recommended service regardless of sex assigned at birth, gender identity, or gender of the individual otherwise recorded by the insurer.	Page: Paragraph or Section:
Hearing aids	ORS 743A.141, HB 4104(2018)	A health benefit plan shall provide payment, coverage, or reimbursement for one hearing aid per hearing impaired ear if necessary for the treatment of hearing loss in an enrollee who is: 18 years of age or younger; or 19 to 25 years of age and enrolled in a secondary school or an accredited educational institution. Consistent with the above age restrictions, coverage requirements must comply with the following • One hearing aid per hearing impaired ear every 36 months or more frequently if modifications to an existing hearing aid will not meet the needs of an enrollee who is under 19 years of age, or 19 to 25 years of age and enrolled in a secondary school or an accredited educational institution; • One box of replacement batteries per year for each hearing aid; • Reimbursement of hearing assist technology systems; • Ear molds and replacement ear molds • Necessary diagnostic and treatment services at least twice per year for enrollees who are younger than four years of age and at least once per year for enrollees who are four years of age or older	Page: Paragraph or Section:

Category	Reference	Description of review standards requirements	Answer
Hearing aids (continued)	ORS 743A.141, HB 4104(2018)	• Hearing tests appropriate for an enrollee's age or developmental need; Bone conduction sound processors, if necessary for appropriate amplification of the hearing loss	Page: Paragraph or Section:
Human Papilloma Virus (HPV) vaccine	ORS 743A.105	Health benefit plans must provide coverage of the human papillomavirus (HPV) vaccine for members.	Page: Paragraph or Section:
Inborn errors of metabolism	ORS 743A.188	All health insurance policies shall include coverage for treatment of inborn errors of metabolism.	Page: Paragraph or Section:
Inmate pre-adjudicated coverage	ORS 743A.260	A plan may not deny claims on the basis that enrollee is in custody of a local supervisory authority	Page: Paragraph or Section:
Mammograms	ORS 743A.100, 42 USC § 300gg-13 45 CFR §147.130 HRSA Guidelines	Coverage provides for mammograms for the purpose of diagnosis in symptomatic or high-risk women at any time upon referral of the woman's health care provider and an annual mammogram for the purpose of early detection for a woman 40 years of age or older, with or without referral from the woman's health care provider. Note: Preventive mammograms covered without coinsurance are required for members aged 40 and older.	Page: Paragraph or Section:
Mastectomy-related services	ORS 743A.110, 29 U.S.C. § 1185b Women's Health & Cancer Act	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. The enrollee is provided a written notice at time of enrollment and annually thereafter describing the coverage for all mastectomy-related services. Include the definition of mastectomy in the contract.	Page: Paragraph or Section:
Maxillofacial prosthetic services	ORS 743A.148	Coverage provides for coverage of maxillofacial prosthetic services necessary for adjunctive treatment.	Page: Paragraph or Section:

Category	Reference	Description of review standards requirements	Answer
Mental or Nervous Conditions and Chemical Dependency	ORS 743A.168, OAR 836-053-1404, OAR 836-053-1405, OAR 836-053-1407, OAR 836-053-1408, OAR 836-053-1409 Bulletin 2014-1, Bulletin 2014-2, 29 CFR §2590.712, 45 CFR §146.136, 45 CFR §147.160,	All plans include coverage for mental or nervous conditions and chemical dependency, including alcoholism. • Coverage must be as broad as and not more restrictive than coverage for other medical conditions. • If the plan provides out-of-network coverage for medical and surgical services, it must also provide out-of-network coverage for this benefit. • Provides coverage for court-ordered screening interviews or treatment programs when a person is convicted of driving under the influence of intoxicants (DUII). • Treatment limits for mental or nervous conditions and chemical dependency must comply with the "substantially all" and "predominately equal to" medical and surgical benefits tests found in federal law. • Quantitative limits applied only to mental health and chemical dependency is not allowed. The final federal rules – issued Nov 13, 2013 Vol. 78, No. 219 (http://www.gpo.gov/fdsys/pkg/FR-2013-11-13/pdf/2013-27086.pdf) • Plans may not impose more stringent utilization review requirements (e.g., preauthorization) for mental health or substance use disorder benefits than imposed on medical/surgical benefits. • The policy and certificate must contain a statement of compliance with state and federal mental health parity.	Pages: Paragraph or Section: Paragraph or Section: Paragraph or Section: Paragraph or Section: Paragraph or Section: Paragraph or Section: Paragraph or Section:
Newborns and mothers	ORS 743B.195, 45 CFR §146.130 45 CFR §148.170	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.	Page: Paragraph or Section:
Nonprescription enteral formula for home use	ORS 743A.070	This policy provides coverage for formula needed to treat severe intestinal malabsorption.	Page: Paragraph or Section:
Orally administered anticancer	ORS 743A.068	The policy provides coverage for oral anticancer medication on a basis no less favorable than intravenously administered or injected medications.	Page: Paragraph or Section:
Pelvic and Pap smear examinations	ORS 743A.104	Coverage provides reimbursement for pelvic and Pap smear exams provided annually for individuals 18 to 64 and any time upon referral of the woman's health care provider.	Page: Paragraph or Section:

Category	Reference	Description of review standards requirements	Answer
Pervasive developmental disorder	ORS 743A.190, ORS 743A.168, 45 CFR 156.125, 45 CFR 146.136, Bulletin 2014-1, Bulletin 2014-2	Pervasive Developmental Disorders (PDD) are now considered mental health conditions and subject to all requirements of federal and state mental health parity laws. Categorical and broad-based treatment exclusions are prohibited. In addition, plans must provide medically necessary services without visit limits including inpatient and outpatient rehabilitative and habilitative services and devices. Bulletin 2014-2 contains additional coverage requirements for Applied Behavior Analysis (ABA) therapy.	Page: Paragraph or Section:
Physical breast examinations	ORS 743A.108*	Coverage includes a complete and thorough physical examination of the breast	Page: Paragraph or Section:
Pregnancy and childbirth expenses	ORS 743A.080, OAR 836-053-0003	Pregnancy care means the care necessary to support a healthy pregnancy and care related to labor and delivery. • Plans must provide payment or reimbursement for expenses associated with pregnancy care and childbirth. • Benefits provided under this section shall be extended to all enrollees, enrolled spouses, and enrolled dependents. A carrier may not impose an exclusion period or a waiver in a health benefit plan for pregnancy and childbirth expenses, for which coverage is required by ORS 743A.080.	Page: Paragraph or Section:
Preventive services	ORS 743A.262, 42 U.S.C. 300gg-13, 45 CFR 147.130, ORS 743A.067, HB 3391(2017), OAR 836-053-0435	Plans must provide coverage of preventive health services, as listed below, and may not impose cost-sharing requirements for preventive services, except as allowed by law. • Evidence-based items or services that have in effect a rating of “A” or “B” in the current recommendations of the United States Preventive Services Task Force • Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention • Evidence-informed preventive care and screenings for infants, children, and adolescents supported by the Health Resources and Services Administration (HRSA)	Page: Paragraph or Section:

Category	Reference	Description of review standards requirements	Answer
Preventive services (continued)	ORS 743A.262 42 U.S.C. 300gg-13, 45 CFR 147.130 ORS 743A.067 HB 3391(2017) OAR 836-053-0435	In addition, preventive care and screenings for women as defined in ORS 743A.067 and HB 3391(2017) • **A and B list for preventive services:** https://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/ • **Women's preventive services**: http://www.hrsa.gov/womensguidelines/ **Note**: For enrollees who do not have Internet access, the insurer must provide a phone number where the information available online will be described. Health benefit plans must provide coverage for well-woman preventive visits as described in ORS 743A.067 and on pages 147 through 151 of the Women's Preventive Service Initiative Report, published December 2016 and available at:¶ http://dfr.oregon.gov/business/insurance-industry/health-ins-regulation/Pages/regulatory-guid.aspx¶ An insurer shall make readily accessible to enrollees and potential enrollees, in a consumer-friendly format, information about the coverage of contraceptives by each health benefit plan and the coverage of other services, drugs, devices, products and procedures described in ORS 743A.067. The insurer must provide the information: • On the insurer's website; and • In writing upon request by an enrollee or potential enrollee.	Page: Paragraph or Section:
Sterilization	ORS 743A.067	The plan must provide coverage for sterilization without coinsurance.	Page: Paragraph or Section:
Telemedical services	ORS 743A.058	Coverage for telemedical services via synchronous two-way video communication. Coverage equal to contract covered services	Page: Paragraph or Section:
Tobacco use Cessation	**Cessation** ORS 743A.170	Coverage to provide payment or reimbursement of at least $500 for tobacco use cessation programs for all enrollees. ***Annual and lifetime dollar limits must be converted to a non-dollar actuarial equivalent.*** **Note: The USPSTF A&B list includes recommended preventive interventions (see 'Preventive Services' above for link).**	Page: Paragraph or Section:

Category	Reference	Description of review standards requirements	Answer
Tobacco use Cessation	**Definition** 45 CFR §147.102(1)(iv)	Tobacco use is defined as use of any tobacco product (except for religious or ceremonial use) on average four or more times per week within no longer than the past six months.	Page: Paragraph or Section:
Traumatic brain injury	ORS 743A.175	Coverage for medically necessary therapy and services for the treatment of traumatic brain injury.	Page: Paragraph or Section:
POLICY PROVISIONS			
Category	Reference	Description of review standards requirements	Answer
Affiliation period	ORS 743B.105(2), 45 CFR 146.121 (b)(1),(ii)(C)	An affiliation period may not exceed two months for an enrollee or three months for a late enrollee.	Page: Paragraph or Section: N/A ☐
Allowable charge methodology	ORS 743B.281-3	A written methodology of how allowable charges are determined.	Page: Paragraph or Section:
Annual and lifetime dollar limits prohibited	45 CFR 147.126, 29 CFR 2590.715-2711	A group health plan may not impose annual or lifetime limits on the dollar amount of essential health benefits.	Page: Paragraph or Section:
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.	Page: Paragraph or Section: N/A ☐
Attorney Fees	ORS 742.061	The policy may not include a provision that eliminates access to attorney fees in a dispute between the carrier and the policyholder.	Page: Paragraph or Section: N/A ☐

Category	Reference	Description of review standards requirements	Answer
Balance billing prohibited for in-network healthcare facility services	ORS 743B.287, HB 2339(2017), HB 1549(2018) Bulletin 2018-02	Balance billing is generally not permitted for services performed by an out of network provider received at an in-network facility. Specific limitations apply.	Confirmed ☐
Beneficiaries	ORS 743.444*	If the policy includes a provision for beneficiaries, the policy must include language from ORS 743.444 or equivalent.	Page: Paragraph or Section: N/A ☐
Cancellation, Nonrenewal And Continuation	Minimum grace period ORS 743B.320	The policy forms shall contain a provision allowing a minimum grace period of 10 days after the premium due date for payment of premium	Page: Paragraph or Section:
	Notice upon termination ORS 743B.320, ORS 743B.323, OAR 836-052-0860	A health benefit plan insurer shall notify the group policyholder when the policy is terminated and the coverage is not replaced by the group policyholder. The notification must: • Explain the rights of the certificate holders regarding continuation of coverage provided by state and federal law. • Be given by mail. • Be mailed not later than 10 working days after the date on which the group policy terminates according to terms of the policy. Each certificate issued under the policy shall also contain a statement describing the above requirements.	Page: Paragraph or Section: Page: Paragraph or Section:
	Separate notice to policyholders ORS 743B.323	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.	Page: Paragraph or Section:
Claims Procedures	Claims procedures 29 CFR 2560.503-1	Claims procedures must include applicable time frames; urgent and concurrent care; ongoing services, treatment, post-service claims; and standards for all required notices.	Page: Paragraph or Section:
	Claims forms ORS 743.426*	The “claim forms” statement in ORS 743.426 or a similar statement is included in the policy	Page: Paragraph or Section: N/A ☐
	Notice of claim ORS 743.423(1)*	The “notice of claims” statement in ORS 743.423(1) or a similar statement is included in the policy.	Page: Paragraph or Section:

Category	Reference	Description of review standards requirements	Answer
Claims Procedures	Time of payment of claims ORS 743.432*	A "time of payment of claims" statement similar to that in ORS 743.432 is included in the policy.	Page: Paragraph or Section:
Confidential Communication Request	ORS 743B.555	A confidential communication request must be available to members. A confidential communication request means a request from an enrollee to a carrier or third party administrator that communications be sent directly to the enrollee and that the carrier or third party administrator refrains from sending communications concerning the enrollee to the policyholder or certificate holder.	Page: Paragraph or Section:
Compliance with Federal and State Law	OAR 836-053-0004	Upon contract issuance or renewal, any insurer offering a health benefit plan must update the plans of the insurer as necessary to comply with state and federal law.	Confirmed ☐
Continuation of coverage	ORS 743B.340(1)(a)	Provides continuation of coverage for strike or lockouts.	Page: Paragraph or Section:
	ORS743B.340(1), OAR 836-082-0055	Provides continuation of coverage for a covered hospitalized individual if policy is canceled and replaced by another insurance carrier.	Page: Paragraph or Section:
	ORS743B.340(2)	Provides uninterrupted coverage when the existing policy is replaced.	Page: Paragraph or Section:
	ORS 743B.342	Every policy of group health insurance shall provide continuation of coverage after injury or illness claim filed for workers' compensation.	Page: Paragraph or Section:

Category	Reference	Description of review standards requirements	Answer
Continuation of coverage, (continued)	ORS 743B.343 to ORS 743B.345	Provides continuation of coverage for surviving, divorced, or separated spouse 55 or older for employers with 20 or more employees. Continuation of coverage is not available to a covered person or qualified beneficiary who is <u>eligible</u> for: • Medicare; or • The same coverage under any other program that was not covering the covered person or qualified beneficiary on the day before a qualifying event. Continuation of coverage is available during the period of family leave on the same terms as if the employee had continued to work. • If family member coverage is provided to the employee, family member coverage must be maintained during the period of family leave. The employee must continue to make any regular contributions to the cost of the health insurance premiums.	Page: Paragraph or Section:
Continuity of Care	ORS 743B.225	Carriers must disclose the availability of continuity of care and comply with all coverage and notice requirements described in statute.	Page: Paragraph or Section:
Coordination of benefits	ORS 743B.475, OAR 836-020-0770 to OAR 836-020-0806	Reduction of benefit payments on the basis of other insurance for the insured individual is in full accordance with coordination-of-benefits rules.	Page: Paragraph or Section:
Dependent coverage	ORS 743B.470	An insurer may not deny enrollment of a child under the health plan of the child's parent on the ground that: (a) The child was born out of wedlock; (b) The child is not claimed as a dependent on the parent's federal tax return; or (c) The child does not reside with the child's parent or in the insurer's service area.	Confirmed ☐
	Dependents age 26 45 CFR 147.120 Natural and adopted children ORS 743A.090	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. "Child" means an individual who is under 26 years of age. Policy covers natural 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.	Page: Paragraph or Section:

Category	Reference	Description of review standards requirements	Answer
Dependent coverage (continued)	Domestic partners ORS 106.300 to ORS 106.340, Bulletin 2008-2	The Oregon Family Fairness Act (ORS 106.300 to 106.340) recognizes and authorizes domestic partnerships in Oregon. • 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. Note: Requirements beyond this are not allowed for same sex domestic partners.	Page: Paragraph or Section:
	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.	Confirmed ☐
Discretionary clauses	ORS742.005(2)(3)(4), 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**.**	Page: Paragraph or Section: N/A ☐
Discrimination	ORS 746.015, OAR 836-080-0050	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	Confirmed ☐
	OAR 836-080-0055	Distinctions based on sex, sexual orientation, or marital status made in the following matters constitute unfair discrimination: • The availability of a particular insurance policy. • The availability of a particular amount of insurance or set of coverage delimiting factors. • The availability of a particular policy coverage or type of benefit, except for those relating to physical characteristics unique to one sex.	Confirmed ☐
	ORS 743B.105(1), 45 CFR §146.121, 45 CFR §147.110	Eligibility is not based on any health status or related factors. The policy does not discriminate against participants and beneficiaries based on a health factor. • Health factors means health status, medical condition, physical illness, mental illness, claims experience, receipt of health care, medical history, genetic information, evidence of insurability, or disability.	Confirmed ☐

Category	Reference	Description of review standards requirements	Answer
Discrimination (continued)	**Diethylstilbestrol use by mother** ORS 743A.088	Insurers may not deny insurance or cancel a health insurance policy because the mother of the insured used drugs containing diethylstilbestrol prior to the insured's birth.	Confirmed ☐
	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. **Note:** Requirements beyond this are not allowed for same sex domestic partner	Page: Paragraph or Section:
	Genetic information 45 CFR §146.122, ORS 746.135	Issuers may not discriminate on the basis of genetic information.	Page: Paragraph or Section:
	Providers 42 USC §300gg–5, 743B.505(2)(a)	The policy and certificate do not discriminate against providers acting within the scope of licensure or certification.	Confirmed ☐
	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	Confirmed ☐
	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.	Confirmed ☐
Dollar limits prohibited on EHBs	ORS 743B.105(9), 45 CFR §147.126 PHSA 2711	A group health benefit plan may not impose annual or lifetime limits on the dollar amount of essential health benefits (EHBs).	Confirmed ☐
Rating period and effective dates	ORS 743B.005(23)	The policy must state the time at which the insurance takes effect and terminates.	Page: Paragraph or Section:
Eligibility	**Employee** ORS 743B.005(7), OAR 836-053-0015 Exhibit 1	An Eligible employee means an employee who is eligible for coverage under a group health benefit plan.	Confirmed ☐

Category	Reference	Description of review standards requirements	Answer
Eligibility (continued)	**Determination** ORS 743B.470(2)	Eligibility for benefits is not determined based on eligibility for Medicaid.	Confirmed ☐
Entire contract	ORS 742.016*, 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.	Page: Paragraph or Section:
Essential health benefits	OAR 836-053-0008, ORS 836-053-0012, 45 CFR §147.150, 42 U.S.C. § 300gg–6(b)	If the large group provides essential health benefits (EHB), they must also follow all requirements related to EHBs (no annual or lifetime dollar limits on EHBs and maximum out of pocket limits for EHBs). The general categories of services: • 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	Yes ☐ N/A ☐
Grace period	ORS 743B.320(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.	Page: Paragraph or Section:

Category	Reference	Description of review standards requirements	Answer
Grandfathered plans	ORS 743B.005(14), 42 USC § 18011(e), 45 CFR §147.140	Plan materials provided to a participant or beneficiary of a grandfathered plan describing the benefits must include a statement indicating: • Insurer believes the plan is a grandfathered plan under the Affordable Care Act (ACA). • Grandfathered plans preserve certain basic health coverage that was already in effect. • Grandfathered health plans may not include certain consumer protections. • Grandfathered plan complies with ACA consumer protections. • Customer service contact information.	Page: Paragraph or Section: N/A ☐
		ERISA plans include one or both of the following items: • 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 non federal governmental plans insert: • You may also contact the U.S. Department of Health and Human Services at https://www.healthcare.gov/	Page: Paragraph or Section: N/A ☐
Grievances, internal appeals and external review	ORS 743B.001(1)(2)(6)(10), OAR 836-053-1030, ORS 743B.250	Include the statutory definition for: • Adverse benefit determination • Authorized representative • Grievance • Internal Appeal	Confirmed ☐
	ORS 743B.250, OAR 836-053-1030, 45 CFR §147.136	Each insurer must furnish written information to policyholders that is required by ORS 743B.250	Confirmed ☐
	Written information to enrollees OAR 836-053-1030(4)	The written information required by ORS 743B.250 must include the information required by ORS 743A.012, relating to coverage of emergency medical conditions and obtaining emergency services, including a statement of the prudent layperson standard for an emergency medical condition (defined in 743A.012). An insurer may use the following statement regarding the use of the emergency telephone number 9-1-1, or other wording that appropriately discloses its use: “If you or a member of your family needs immediate assistance for a medical emergency, call 9-1-1 or go directly to an emergency room.”	Page: Paragraph or Section:

Category	Reference	Description of review standards requirements	Answer
Grievances, internal appeals and external review, (continued)	**Internal appeals**	**The following must be disclosed:**	
	ORS 742.005, ORS 743B.250, OAR 836-053-1100	• The plan includes a grievance process as required by state law. • The plan includes proper adverse benefit determination and IRO requirements per state law. • Information on the grievance process is explained in the policy and certificate	Confirmed ☐
	External appeals	**The insurer must have a process in place for an external review with an Independent Review Organization and the following must be disclosed:**	
	ORS 743B.252, OAR 836-053-1030	A disclosure that the enrollee may request and receive from the insurer the information the insurer is required to disclose under ORS 743B.250.	Page: Paragraph or Section:
	ORS 743B.250, OAR 836-053-1030(12)^	Insurers must disclose that the following additional information is available upon request**:**	Page: Paragraph or Section:
	ORS 743B.250, OAR 836-053-1030(12)^	The notice must also include a statement that the following additional information may be available from the Department of Consumer and Business Services: • Annual summary of grievance and appeals • Annual summary of utilization review policies • Annual summary of quality assessment activities • Results of all publically available accreditations surveys • Annual summary of the insurer's health promotion and disease prevention activities • Annual summary of scope of network and accessibility of services **Note:** the incorrect URL is listed in OAR 836-053-1030(6). http://dfr.oregon.gov/Pages/index.aspx We will be doing future rulemaking to update this link in the rule.	Page: Paragraph or Section:
	Cultural and Linguistic Appropriateness OAR 836-053-1033	All notices and communications required must be provided in a manner that is culturally and linguistically appropriate, as required by ORS 743B.250 and ORS 743B.252.	Confirmed ☐
	ORS 731.036(6)(d)(B) **(self insured public entities only)**	Enrollees must be provided copies of summary plan descriptions including the program's grievance and appeal process.	Page: Paragraph or Section: NA ☐

Category	Reference	Description of review standards requirements	Answer
Guaranteed availability	ORS 743B.003(1),(6), 45 CFR §147.104	A health insurance issuer that offers health insurance coverage in the large group market must offer to any employer all products that are approved for sale in the applicable market, and must accept any employer that applies for any of those products.	Page: Paragraph or Section:
Guaranteed renewability	ORS 743B.105(5), OAR 836-053-0230(8), 45 CFR §146.152, 45 CFR §147.106	The policy guarantees the renewability of insurance coverage in compliance with the federal mandate. • An issuer that offers health insurance coverage must renew or continue in force coverage at the option of the plan sponsor. • An issuer may only non-renew in the event of nonpayment of premiums, fraud, violation of participation or contribution rates, market exit, movement outside the service area, or cessation of association membership.	Page: Paragraph or Section:
Health Savings Accounts	OAR 836-053-0011	If a plan or product is HSA eligible under applicable federal law, the insurer or health care service contractor shall clearly indicate on any applicable plan and benefits template or other plan or product specific filing document that the plan is HSA eligible.	Confirmed ☐
HIPAA requirements	45 CFR Part 160, 45 CFR Part 164	Policy meets all HIPAA privacy requirements and all HIPAA-related statements are solely supported by HIPAA requirements.	Confirmed ☐
Incontestability	ORS 743.414(3)*	The policy contains a provision similar to: “After this policy has been in force for a period of two years during the lifetime of the insured (excluding any period during which the insured is disabled), it shall become incontestable as to the statements contained in the application.”	Page: Paragraph or Section:
Inducements not specified in policy	ORS 746.035	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.	Page: Paragraph or Section:
Late enrollees **Special Enrollment**	ORS 743B.005(19), ORS 743B.105(3), ORS 743B.105(2)(b), 45 CFR §147.116	Late enrollees may be subjected to a group eligibility waiting period that does not exceed 90 days.	Page: Paragraph or Section:
Legal actions	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.	Page: Paragraph or Section:

Category	Reference	Description of review standards requirements	Answer
Notification of changes to preventive benefits	45 CFR §147.130(b)(2)	When making any material modification including changes in preventive benefits, at any time other than renewal, issuer must provide • 60 days advance notice to enrollees before the effective date to let the consumer know that the preventive benefit will now be covered. • Federal law requires plans to cover recommended preventive services with zero cost share no later than 12 months from the date the recommendation is released.	Confirmed ☐
Out of pocket maximum for essential health benefits	42 USC §300gg–6	The ACA requires issuers of health benefit plans to limit out-of-pocket maximums on essential health benefits. • Large groups may not include a separate out-of-pocket maximum for pharmacy, mental health, or substance abuse benefits. • The cost sharing for these benefits must be included in the major medical out-of-pocket maximum.	Page: Paragraph or Section:
Participation, contribution, and eligibility requirements	OAR 836-053-0221(1), ORS 746.240, ORS 743B.105	For every group health benefit plan, a carrier that chooses to enforce participation, contribution or eligibility requirements must: • Specify in the plan all of participation, contribution and eligibility requirements that have been agreed upon by the carrier and the group; and • Apply the participation and eligibility requirements uniformly to all categories of eligible members and their dependents.	Page: Paragraph or Section:
Physical examinations and autopsy	ORS 743.438*	The policy shall contain a similar provision as follows: "PHYSICAL EXAMINATIONS AND AUTOPSY: The insurer at its own expense shall have the right and opportunity to examine the person of the insured when and as often as it may reasonably require during the pendency of a claim hereunder and to make an autopsy in case of death where it is not forbidden by law."	Page: Paragraph or Section: N/A ☐
Preexisting condition exclusion prohibition	45 CFR §147.108, ORS 743B.105	The policy and certificate do not apply preexisting exclusion periods.	Confirmed ☐
Utilization review	ORS 743B.423, OAR 836-053-1030(8), OAR 836-053-1140	Utilization review requirements (prior authorization and appeal process). **OR** "Utilization review" means a set of formal techniques used by an insurer or delegated by the insurer designed to monitor the use of or evaluate the medical necessity, appropriateness, efficacy or efficiency of health care services, procedures or settings.	Page: Paragraph or Section:

Category	Reference	Description of review standards requirements	Answer
Utilization review	**Prior Authorization** ORS 743B.420, 743B.522 ORS 743B.423 OAR 836-053-1200 SB 249(2019)	"Prior authorization" means a determination by an insurer prior to provision of services that the insurer will provide reimbursement for the services • Policy describes prior authorization and binding periods. • Prior authorization determinations relating to benefit coverage and medical necessity shall be binding on the insurer if obtained no more than 30 days prior to the date the service is provided. • A provider request for prior authorization of nonemergency service must be answered within two business days.	Page: Paragraph or Section:
Prior authorization requirements	ORS 743B.420, OAR 836-053-1200	Except in the case of misrepresentation, prior authorization determinations shall be subject to the following requirements: • Prior authorization determinations relating to benefit coverage and medical necessity shall be binding on the insurer if obtained no more than 30 days prior to the date the service is provided. • Prior authorization determinations relating to enrollee eligibility shall be binding on the insurer if obtained no more than five business days prior to the date the service is provided.	Page: Paragraph or Section:
	HB 3440(2017): opioid withdrawal meds	In reimbursing the cost of medication prescribed for the purpose of treating opioid or opiate withdrawal, an insurer offering a health benefit plan as defined in ORS 743B.005 may not require prior authorization of payment during the first 30 days of treatment.	Page: Paragraph or Section:
Proof of loss	OAR 836-080-0230 and 0235 ORS 743B.450	If the policy includes claim procedures, the procedures and timelines comply with fair claim practice requirements. Prompt payment of claims; limits on use of electronic payment methods	Page: Paragraph or Section:
Pharmacists	ORS 743A.051	Whenever the plan provides for payment or reimbursement for a service that is within the lawful scope of practice of a pharmacist, the insurer may provide payment or reimbursement for the service when the service is provided by a pharmacist	Page: Paragraph or Section:
Rebates	ORS 746.045(1)	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	Confirmed ☐
Representations, not warranties	ORS 743.406	Policy shall contain 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.	Page: Paragraph or Section:

Category	Reference	Description of review standards requirements	Answer
Rescissions	ORS 743B.105(8), ORS 743B.310, OAR 836-053-0825, 45 CFR §147.128	Recessions include the following: • Clear identification of the alleged fraudulent act, practice or omission or the intentional misrepresentation of material fact underlying the rescission. • An explanation of why the act, practice or omission was fraudulent or was an intentional misrepresentation of a material fact. • A statement explaining an enrollee's right to file a grievance or request a review of the decision to rescind coverage. • A description of the health carrier's applicable grievance procedures, including any time limits applicable to those procedures 30 days' advance written notice, in the form and manner prescribed by the department, to each plan enrollee or policy holder who would be affected by the rescission of coverage. • Notice of the rescission to the department in the form, manner and time frame prescribed by the department.	Page: Paragraph or Section:
Risk sharing	ORS 743B.250, OAR 836-053-1030(10)	If the plan includes risk-sharing arrangements with providers, the EOC must define risk-sharing and contain a disclosure that additional information is available upon request.	Page: Paragraph or Section: N/A ☐
State hospitals	ORS 743A.010	Policy does not exclude benefits for covered services because they were provided by any hospital owned or operated by the state of Oregon, or any state approved community mental health and developmental disabilities program.	Confirmed ☐
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	Page: Paragraph or Section:
Time limit on certain defenses	ORS 743.414(1)(2)*	The policy contains a provision similar to: "After two years from the date of issue of this policy no misstatements, except fraudulent misstatements, made by the applicant in the application for such policy shall be used to void the policy or to deny a claim for loss incurred or disability, as defined in the policy, commencing after the expiration of that period."	Page: Paragraph or Section:

Category	Reference	Description of review standards requirements	Answer
Underwriting, enrollment, and benefit design requirements	OAR 836-053-0211(2), OAR 836-053-0230	A carrier issuing a group health plan may not: • Modify health insurance with respect to an employee or any eligible dependent by means of a rider, endorsement or otherwise, for the purpose of restricting or excluding coverage for certain diseases or medical conditions otherwise covered by the health benefit plan; • Decline to offer coverage to any eligible member of a group; • Delay enrollment for an otherwise eligible member of the group or dependent for reasons related to actual or expected health status, race, color, national origin, sex, sexual orientation as defined in ORS 174.100, age or disability.	Confirmed ☐
Utilization review	ORS 743B.423, OAR 836-053-1030(8), OAR 836-053-1140	Utilization review requirements (prior authorization and appeal process).	Page: Paragraph or Section:
Waiting period	ORS 743B.005(15), 45 CFR §147.116, ORS 743B.105(2)(a)	Policy describes group eligibility waiting period. A group health plan must not apply any waiting period that exceeds 90 days.	Page: Paragraph or Section:
PROVIDER REIMBURSEMENTS			
Category	Reference	Description of review standards requirements	Answer
Acupuncturist	ORS 743A.020	Plans providing coverage for acupuncture services performed by a physician must also provide coverage when performed by an acupuncturist.	Page: Paragraph or Section: N/A ☐
Ambulance	ORS 743A.014*	If the policy provides coverage for ambulance care and transportation, the insurer shall indemnify directly the provider of the ambulance care and transportation.	Page: Paragraph or Section: N/A ☐
Clinical pharmacy	ORS 743A.051	When a plan provides payment or reimbursement for a service that is within the lawful scope of practice of a pharmacist, the insurer may provide payment or reimbursement when the service is provided by a pharmacist. (Effective for plans beginning on or after 1/1/2016.)	Confirmed ☐
Clinical social worker	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.	Page: Paragraph or Section: N/A ☐

Category	Reference	Description of review standards requirements	Answer
Community Assessment centers	ORS 743A.252*	Insurers are required to reimburse community assessment centers for child abuse medical assessments and related services.	Confirmed ☐
Dentist	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.	Page: Paragraph or Section: N/A ☐
Denturist	ORS 743A.028*	If the contract covers services provided by a denturist, the same coverage should be extended when the services are provided by a licensed dentist.	Page: Paragraph or Section: N/A ☐
Direct payments to providers	ORS 743B.462	Reimbursement of claims.	Page: Paragraph or Section: N/A ☐
Expanded practice dental hygienist	ORS 743A.034	Any policy covering dental health that provides for a dentist must also provide coverage for an expanded practice dental hygienist.	Page: Paragraph or Section: N/A ☐
Licensed professional counselors and licensed marriage and family therapists	ORS 743A.052*	If the plan provides for coverage for services performed by a clinical social worker or nurse practitioner, the plan also must cover services provided by a licensed professional counselor or marriage and family therapist when the counselor or therapist is acting within the counselor's or therapist's lawful scope of practice.	Page: Paragraph or Section: N/A ☐
Naturopathic physicians	ORS 743B.407	An insurer shall provide a naturopathic physician the choice of applying to be credentialed by the insurer or as a primary care provider or as a specialty care provider	Page: Paragraph or Section: N/A ☐
Nurse practitioner or physician assistant	ORS 743A.036	Whenever any policy of health insurance provides for reimbursement for a primary care or mental health service provided by a licensed physician, the insured under the policy is entitled to reimbursement for such service if provided by a licensed physician assistant or a certified nurse practitioner if the service is within the lawful scope of practice of the physician assistant or nurse practitioner.	Page: Paragraph or Section: N/A ☐

Category	Reference	Description of review standards requirements	Answer
Optometrist/ Vision care providers	ORS 743A.040*, ORS 750.065, ORS 743B.406	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.	Page: Paragraph or Section:
Pediatrician access	45 CFR §147.138	If the plan mandates designation of a primary care physician, the plan must allow the policyholder to designate any willing in-network pediatrician as a child's primary care physician.	Page: Paragraph or Section: N/A ☐
Pharmacists	ORS 743A.051	Whenever the plan provides for payment or reimbursement for a service that is within the lawful scope of practice of a pharmacist, the insurer may provide payment or reimbursement for the service when the service is provided by a pharmacist	Page: Paragraph or Section:
Physician assistant	ORS 743A.044*	Claims submitted directly by a physician assistant, are to be paid as if submitted by the supervising physician.	Page: Paragraph or Section:
Psychologist	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.	Page: Paragraph or Section: N/A ☐
Women's health care provider	ORS 743B.222(1)(2)(3), 45 CFR §147.138	Whenever a plan requires an enrollee to designate a primary care provider, the plan must permit enrollee to designate a woman's health care provider as her primary care provider. Whenever a plan requires an enrollee to designate a primary care provider, the plan must permit a female enrollee to have direct access to a women's health care provider	Page: Paragraph or Section: N/A ☐
Workers' compensation claims	**Work related injuries** ORS 743B.342, ORS 743B.810, OAR 836-053-0100, OAR 836-053-0105	Requires a health benefit plan to provide coverage for a work-related injury or occupational disease claim denied or not yet adjudicated by the workers' compensation carrier. .	Confirmed ☐

PRESCRIPTION DRUGS			
Category	Reference	Description of review standards requirements	Answer
90 day supply of prescription	ORS 743A.063	A health benefit plan that provides coverage for a prescription drug benefit program must provide reimbursement for up to a 90-day supply of a prescription drug dispensed by a pharmacy.	Page: Paragraph or Section:
Prescription drugs	ORS 743A.062	Prescription drug coverage 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.	Page: Paragraph or Section:
Prescription drug step therapy	ORS 743B.602	A health benefit plans that provides prescription drug benefit is required to provide provider with an explanation of its prescription drug step therapy protocol and the mechanism for seeking override of the protocol.	Yes ☐ N/A ☐
Prescription drug synchronization	ORS 743B.601	A health plan that includes prescription drug coverage it must implement a synchronization policy for the dispensing of prescription drugs to the plan's enrollees.	Yes ☐ N/A ☐