

**Department of Consumer and Business Services
Division of Financial Regulation**

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**Standard Provisions for Small Employer Health Benefit Plan
FORM FILINGS**

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

The standards are summaries; review of the underlying regulatory guidance 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. Not including required information or policy provisions will result in delays.

Insurer name: _____

Request effective date: _____

TOI (type of insurance): H16G Group Health - Major Medical
 H15G.003 Group Health – Hospital/Surgical/Medical Expense

Sub-TOI: H16G.003A Small Group Only – PPO H16G.003E Small Group Only - POS Basic
 H16G.003B Small Group Only - PPO Basic H16G.003G Small Group Only - Other
 H16G.003D Small Group Only – POS H15G.003H Small Group Only-EPO

Type of group: Oregon Small Employer (as defined in ORS 743B.005)

** Indicates Oregon standard does not apply to Health Care Service Contractors per ORS 750.055, but may be subject to federal standard.*

GENERAL REQUIREMENTS (FOR ALL FILINGS)			
Category	Reference	Description of review standards requirements	Answer
Submission package requirements	SERFF or Division of Financial Regulation's website : OAR 836-010-0011	The following 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 copy of the revised form to identify the modification, revision, or replacement language.) 7. Statement of Variability (see "Variability in forms" section).	Yes N/A <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Filing description or cover letter	ORS 731.296 OAR 836-010-0011(4)	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 form. 3. The differences between in-network and out-of-network. 4. The contact information of two people from your company that can discuss the filing. 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 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Purpose of filing	ORS 742.003(1), OAR 836-010-0011(3)	The following are submitted in this filing for review: 1. New policy. 2. Changes to a previously-approved form includes highlighted/ redline version. 3. Endorsements and/or amendments 4. Riders for non-standard plans only: a) If submitting separate riders forms under the Forms Schedule Tab the rider provision must be embedded into both the policy & certificate using variability; or b) Include two policies and certificates (one with the rider(s) and one without rider(s)).	Yes N/A <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Clear policy language	ORS 742.005(2), ORS 743.103, ORS 743.106(1)(a-d), ORS 743.104(2), ORS 743.405(5)	1. The information is clear and understandable to the consumer and is not ambiguous, abstruse, unintelligible, uncertain, or likely to mislead. 2. The style, arrangement, and overall appearance of the policy may not give undue prominence to any portion of the text. 3. 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. 4. The font shall be uniform and not less than 12-point type	Confirmed <input type="checkbox"/>

Category	Reference	Description of review standards requirements	Answer
Cover page	ORS 743.492, OAR 836-010-0011	<ol style="list-style-type: none"> 1. The full corporate name of the insuring company appears prominently on the first page of the policy. 2. A marketing name or insurer logo, if used on the policy, does not mislead as to the identity of the insuring company. 3. The insuring company's address, consisting of at least a city and state, appears on the first page of the policy. 4. The signatures of at least one company officer appears on the first page of the policy. 5. The policy includes a right-to-examine provision that appears on the cover page. 6. The policy contains a brief caption that appears prominently on the cover page and describes the type of coverage. 	Yes N/A <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Form numbers	OAR 836-010-0011, ORS 743.405(7)	Each form constituting the policy, including riders and endorsements, must be identified by a form number in the lower left-hand corner on each page of the form.	Confirmed <input type="checkbox"/>
Written information to enrollees	743B.250, OAR 836-053-1010, OAR 836-053-1030, OAR 836-053-1033, OAR 836-053-1035, 45 CFR 147.200	<p>An insurer must provide a written summary of the policy required by ORS 743B.250 to each enrollee, as part of the written general information that is furnished as required by ORS 743B.250 and OAR 836-053-1030, relating to services, access thereto and related charges and scheduling.</p> <p>All notices and communications required to be provided by an insurer to enrollees under ORS 743B.250 and 743B.252 must be provided in a manner that is culturally and linguistically appropriate, as required by ORS 743.804.</p>	Confirmed <input type="checkbox"/>
Variability in forms	ORS 742.003, ORS 742.005(2)	<p>Variable material in forms will only be permitted if it is clearly identified by brackets along with a complete explanation of when each would be used.</p> <ol style="list-style-type: none"> 1. Variable text includes all optional text, changes in language, and choices in terms or provisions. 2. Variable numbers are limited to discreet values within a defined range from minimum to maximum benefit amounts. 3. Variability may be described either through embedded Drafter's Notes or within a separate Statement of Variability (SOV) included as a form; due to ease of review, DFR prefers embedded drafters' notes. <p>Note: Variability guideline instructions are found at: http://dfr.oregon.gov/rates-forms/Documents/health-variability-guidelines.pdf</p>	Yes N/A <input type="checkbox"/> <input type="checkbox"/>
Groups separated	OAR 836-010-0011	Only include small group coverage in this filing and submit any large group coverage in a separate filing with the appropriate TOI and SERFF filing requirements.	Confirmed <input type="checkbox"/>

APPLICABILITY			
Category	Reference	Description of review standards requirements	Answer
Applications	Form 440-2442H 45 CFR §146.121, 45 CFR §147.110	If an application is submitted in the filing, also complete and submit <i>Standards for Health Applications</i> (Form 440-2442H).	Yes <input type="checkbox"/> N/A <input type="checkbox"/>
Assumption certificates	Form 440-3637	File under <i>Changes to Business Operations that Require a Filing</i> (Form 440-3637).	
Modification and discontinuation	OAR 836-053-0002, 45 CFR 147.106, 45 CFR 148.122, Form 440-2896	Submit transmittal and requirements for <i>Modification and Discontinuance of Health Benefit Plans</i> (Form 440-2896) when making a uniform modification or discontinuing a plan. Please identify which of the following notices will be used: State or Federal. Note: Carriers may submit the transmittal in this form filing, rate filing, or separately	Yes <input type="checkbox"/> N/A <input type="checkbox"/>
Pediatric dental embedded in the medical form	Form 440-4978	If pediatric dental is embedded in the medical policy, please also submit <i>Standard Provisions for Exchange Certified Pediatric Dental (ACA compliant) Forms</i> (Form 440-4978). Note: Carriers are only required to complete the sections on covered and non-covered services and the section 'the Standard Provisions for Exchange Certified Pediatric Dental'.	Yes <input type="checkbox"/> N/A <input type="checkbox"/>
Third Party Payments	45 CFR 156.1250, SB 560, HB 4113(2024)	Carriers must accept payments from third parties as described in state and federal law.	Yes <input type="checkbox"/> N/A <input type="checkbox"/>

BENEFIT REIMBURSEMENT

Category	Reference	Description of review standards requirements	Page and paragraph
New coverage requirements beginning plan year 2022	OAR 836-053-0017 EHB 731.097	In addition to any other benefits required under state or federal law, a health benefit plan required to provide essential health benefits within the meaning of ORS 731.097 must, at a minimum, provide coverage for the following items and services: <ul style="list-style-type: none"> • Coverage for up to 20 spinal manipulation visits per year • Coverage for up to 12 acupuncture visits per year • Removal of barriers to prescribing Buprenorphine for medication-assisted treatment of opioid use disorder; and • Coverage of at least one intranasal spray opioid reversal agent for opioid prescriptions of 50 MME or higher. 	Page: _____ Paragraph or Section: _____ N/A <input type="checkbox"/>
Behavioral and physical health services provided same day or same facility.	ORS 743A.169	Behavioral and physical health services provided in the same facility or on the same day are subject to the coverage requirements listed in ORS 743A.169	Page: _____ Paragraph or Section: _____ N/A <input type="checkbox"/>

BENEFIT REIMBURSEMENT

Category	Reference	Description of review standards requirements	Page and paragraph
Bilateral cochlear implants	ORS 743A.140, HB 4104(2018)	Must reimburse the cost of bilateral cochlear implants, including the cost of repair and replacement parts, if medically appropriate for the treatment of hearing loss. The coverage required is not subject to the deductible except as allowed in ORS 742.008.	Page: _____ Paragraph or Section: _____ N/A <input type="checkbox"/>
Child abuse assessments.	ORS 743A.252	A health benefit plan shall provide payment to or reimburse a children’s advocacy center for the services provided by the center in conducting a child abuse assessment of a child enrolled in the plan, and that are related to the child abuse assessment including a forensic interview and mental health treatment.	Page: _____ Paragraph or Section: _____ N/A <input type="checkbox"/>
Clinical trials	ORS 743A.192, PHSA 2709 42 USC 300gg-8	The policy must comply with both Oregon and federal clinical trial mandates.	Page: _____ Paragraph or Section: _____

Category	Reference	Description of review standards requirements	Page and paragraph
Colorectal cancer screenings and laboratory tests	ORS 743A.124 USPSTF A and B List CMS FAQ 51	<p>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.</p> <p>For members aged 45 and older, an insurer may not impose cost sharing on the colorectal cancer screening, examinations and lab tests and must cover, at a minimum:</p> <ul style="list-style-type: none"> • 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. <p>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.</p> <p>Please see CMS FAQ 51 for further clarification regarding expanded coverage expectations for preventive colonoscopies including:</p> <ul style="list-style-type: none"> • Required specialist consultation prior to the screening procedure; • Bowel preparation medications prescribed for the screening procedure; • Anesthesia services performed in connection with a preventive colonoscopy; • Polyp removal performed during the screening procedure; • Any pathology exam on a polyp biopsy performed as part of the screening procedure; and • Abnormal findings identified by flexible sigmoidoscopy or CT colonography screening require follow-up colonoscopy for screening benefits to be achieved. 	Page: _____ Paragraph or Section: _____
Contraception prescribed by pharmacists	HB 2879(2015), HB 2527(2017), ORS 743A.066, ORS 689.005, ORS 689.683	<p>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.</p> <p>Contraceptive benefit allows a pharmacist to:</p> <ul style="list-style-type: none"> • 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: _____

Category	Reference	Description of review standards requirements	Page and paragraph
Confidential Communication Request	ORS 743B.005, ORS 743B.250, ORS 743B.555 OAR 836-053-0610	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 <input type="checkbox"/>
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.	Page: _____ Paragraph or Section: _____
Diabetes management for pregnant women	ORS 743A.067 ORS743A.082	A policy may not require a copayment or impose a coinsurance requirement or a deductible 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. Code § 223	Page: Paragraph or Section:
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 <input type="checkbox"/>
Emergency services - Nonparticipating providers	ORS 743A.012(3)(b), 45 CFR §147.138(b)	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.	Page: Paragraph or Section: N/A <input type="checkbox"/>
Emergency services	ORS 743A.012 45 CFR §147.138(b) ORS 743B.250(1)(j)	Health benefit plans shall provide coverage without prior authorization for emergency services as specified in the listed state and federal laws.	Page: Paragraph or Section:

Category	Reference	Description of review standards requirements	Page and paragraph
Emergency services - Information to enrollees	ORS 743A.012(4)(5) ORS 743B.250 OAR 836-053-1030	<p>Health benefit plans shall provide information to enrollees in plain language and as specified in ORS 743A.012 regarding:</p> <ul style="list-style-type: none"> 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. <p>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.</p>	<p>Page: _____ Paragraph or Section: _____</p> <p>N/A <input type="checkbox"/></p>
Gender Affirming Care	ORS 743A.325, HB 2002(2023), Bulletin 2024-2, ORS 742.005(4)	<p>A carrier offering a health benefit plan in this state may not:</p> <ul style="list-style-type: none"> • Deny or limit coverage under the plan for gender-affirming treatment that is: <ul style="list-style-type: none"> ○ Medically necessary as determined by the physical or behavioral health care provider who prescribes the treatment; and ○ Prescribed in accordance with accepted standards of care. • Apply categorical cosmetic or blanket exclusions to medically necessary gender-affirming treatment. • Exclude as a cosmetic service a medically necessary procedure prescribed by a physical or behavioral health care provider as gender-affirming treatment • Issue an adverse benefit determination denying or limiting access to gender-affirming treatment unless a physical or behavioral health care provider with experience prescribing or delivering gender-affirming treatment has first reviewed and approved the denial of or the limitation on access to the treatment. 	<p>Page: _____ Paragraph or Section: _____</p>

Category	Reference	Description of review standards requirements	Page and paragraph
Hearing aids and hearing care treatment	ORS 743A.141, OAR 836-053-0012, HB 2994(2023), HB 4104(2018), Bulletin 2018-8	Provides payment, coverage, or reimbursement for coverage of hearing aids and hearing aid related services and supplies consistent with ORS 743A.141 and OAR 836-053-0012(3)(a)(C). The coverage required is not subject to the deductible except as allowed in ORS 742.008.	Page: _____ Paragraph or Section: _____
Oregon Universal Newborn Nurse Home Visiting Program	ORS 743A.078, SB 1555(2022)	In accordance with 2019 Oregon Senate Bill 526 (2019), this plan will cover the cost of universal newborn nurse home visiting services prescribed by rule by the Oregon Health Authority (OHA) under Section 1(7) of Chapter 522, 2019 Oregon Laws. Coverage will be provided on behalf of a newborn child, up to the age of six months, who is enrolled under the plan and who resides in an area of state that is served by a universal newborn nurse home visiting program approved by the OHA. Coverage for universal newborn nurse home visits as described above is not subject to cost sharing, coinsurance, or deductibles [unless required for the purpose of maintaining HDHP status as required by IRS law].	Page: _____ Paragraph or Section: _____
HPV vaccine	ORS 743A.105	A policy must provide coverage of the human papillomavirus (HPV) vaccine for members.	Page: _____ Paragraph or Section: _____
Inborn errors of metabolism	ORS 743A.188	Coverage includes 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.	Confirmed <input type="checkbox"/>
Lung cancer screening: New A and B item beginning March 2022	45 CFR 147.130(b)	Lung cancer screening for adults aged 50-80 if they've smoked in the preceding 15 years. This coverage will take effect for group policies renewing on or after March 2022.	Confirmed <input type="checkbox"/>

Category	Reference	Description of review standards requirements	Page and paragraph
Breast Examinations and Mammograms	ORS 743A.100, ORS 743A.067, ORS 743A.101, 42 USC § 300gg-13, 45 CFR §147.130, HRSA Guidelines SB 1041(2023)	<p>Except as provided in ORS 742.008, a carrier offering a group health benefit plan or an individual health benefit plan in this state that reimburses the cost of supplemental or diagnostic breast examinations may not impose on the coverage of a medically necessary supplemental or diagnostic breast examination: (a) A deductible; (b) Coinsurance; (c) A copayment; or (d) Other out-of-pocket expenses.</p> <p>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.</p> <p>Note: Preventive mammograms covered without coinsurance are required for members aged 40 and older.</p>	Page: _____ Paragraph or Section: _____
Mastectomy-related services	ORS 743A.110 ORS 743A.111, 42 U.S.C. § 300gg-27 Women's Health and Cancer Rights Act of 1998	<p>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.</p> <p>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.</p>	Page: _____ Paragraph or Section: _____
Maxillofacial prosthetic service	ORS 743A.148	Coverage includes maxillofacial prosthetic services considered necessary for adjunctive treatment.	Page: _____ Paragraph or Section: _____

Category	Reference	Description of review standards requirements	Page and paragraph
Behavioral health	HB 3046(2021) ORS 743A.168, ORS 743A.190, OAR 836-053-1403 to 1408, Bulletin 2014-1, Bulletin 2014- 2, 29 CFR §2590.712, 45 CFR §146.136, 45 CFR §147.160	<p>All plans provide coverage for expenses arising from the diagnosis of behavioral health conditions and medically necessary behavioral health treatment 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.</p> <ul style="list-style-type: none"> • A Behavioral Health Condition means any mental or substance use disorder covered by diagnostic categories listed in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision (DSM-5-TR), the International Classification of Diseases, 10th Revision (ICD-10), or the International Classification of Diseases, 11th Revision (ICD-11) • All definitions and policy language and coverage requirements must align with updated language found in HB 3046 (2021) and related rulemaking. • If the plan provides out-of-network for other benefits, 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 must comply with the “substantially all” and “predominately equal to” tests. • Quantitative limits applied only to mental health and chemical dependency are 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 that indicates the policy is compliant with state and federal mental health parity. 	Page: _____ Paragraph or Section: _____

Category	Reference	Description of review standards requirements	Page and paragraph
Newborns and mothers	ORS 743B.195, 45 CFR 146.130, PHSA 2725	Coverage provides 48 hours of care for vaginal delivery and 96 hours for cesarean 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	The policy provides coverage for formula needed to treat severe intestinal malabsorption.	Page: _____ Paragraph or Section: _____
Orally administered anticancer medication	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: _____
Orthotic and prosthetic devices	ORS 743A.145, SB 797(2023)	provide coverage for prosthetic and orthotic devices that are medically necessary to restore or maintain the ability to complete activities of daily living or essential job-related activities and that are not solely for comfort or convenience. The coverage required by this subsection includes all services and supplies medically necessary for the effective use of a prosthetic or orthotic device, including design formulation, fabrication, material and component selection, measurements, fittings, static and dynamic alignments and patient instruction in the use of the device.	Page: _____ Paragraph or Section: _____
PANS/PANDA	ORS 743A.315, SB 628(2023)	A health benefit plan must cover the cost of up to three monthly immunomodulatory courses of intravenous immunoglobulin therapy for the treatment of pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections and pediatric acute-onset neuropsychiatric syndrome, when specific conditions are met.	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	Page and paragraph
Pervasive developmental disorder	ORS 743A.190, ORS 743A.168, 45 CFR 156.125, 45 CFR 146.136, Bulletin 2014-1, Bulletin 2014-2	<p>Pervasive Developmental Disorders (PDD) are considered mental health conditions and subject to all requirements of federal and state mental health parity laws.</p> <ul style="list-style-type: none"> • Categorical and broad-based treatment exclusions are prohibited. • Plans must provide medically necessary services without visit limits. • Plans must include inpatient and outpatient rehabilitative and habilitative services and devices. <p>Bulletin 2014-2 contains additional coverage requirements for Applied Behavior Analysis (ABA) therapy.</p>	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	<p>Pregnancy care means the care necessary to support a healthy pregnancy and care related to labor and delivery.</p> <ul style="list-style-type: none"> • 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. <p>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.</p>	Page: _____ Paragraph or Section: _____

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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	<p>For non-grandfathered 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 federal law.</p> <ul style="list-style-type: none"> • 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) <p>In addition, preventive care and screenings as defined in ORS 743B.067 and HB 3391(2017)</p> <ul style="list-style-type: none"> • 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/ • Please review this list for updated coverage requirements for 2022. There are several new items for the coming plan year. <p>Note: For enrollees who do not have Internet access, the insurer must provide a phone number where the information available online will be described.</p> <p>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:</p> <ol style="list-style-type: none"> (a) On the insurer’s website; and (b) In writing upon request by an enrollee or potential enrollee. <p>Post-exposure prophylactic antiretroviral drugs (PrEP) now qualify as a preventive medication per the USPSTF and ORS 743B.425 and may not be subject to prior-authorization or restrict coverage to in-network pharmacists or pharmacies.</p>	Page: _____ Paragraph or Section: _____

Category	Reference	Description of review standards requirements	Page and paragraph
Primary care visits	ORS 743A.310, SB 1529(2022), HB 2008(2023), OAR 836-053-0027, OAR 836-053-0028	<p>An individual or group policy or certificate of health insurance that is not offered on the health insurance exchange and that reimburses the cost of hospital, medical or surgical expenses, other than coverage limited to expenses from accidents or specific diseases and limited benefit coverage, shall, in each plan year, reimburse the cost of at least three primary care visits for behavioral health or physical health treatment.</p> <p>An insurer that offers a qualified health plan on the health insurance exchange must offer at least one plan in each metal tier offered by the insurer</p>	Page: _____ Paragraph: _____
Proton beam therapy	ORS 743A.130 SB 2(2021), SB 463(2023)	Provide coverage for proton beam therapy for the treatment of cancer on a basis no less favorable than the coverage of radiation therapy.	Page: _____ Paragraph: _____
Reproductive Health Services	ORS 743A.066, ORS 743A.067, PHSA 2713, 45 CFR 147.130, 42 U.S. Code § 300gg-13 HRSA Guidelines HB 2002(2023)	<p>A health benefit plan offered in this state must provide coverage for all of the services, drugs, devices, products and procedures listed in ORS 743A.067 and related federal and state laws. The coverage must be provided without a deductible, coinsurance, copayment or any other cost-sharing requirement for all services, drugs, devices, products and procedures listed in 743A.067(2) with the exception of the allowance provided in 743A.067(10).</p> <p>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 persons with reproductive capacity, as prescribed by a provider.</p> <p>Plan must reimburse health care provider or dispensing entity for a dispensing of a contraceptive intended to last for:</p> <ul style="list-style-type: none"> • 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. • Over the counter contraceptive drugs must be covered in accordance with ORS 743A.067(2)(j)(c). 	Page: _____ Paragraph or Section: _____
Telemedical services	ORS 743A.058	Must provide coverage of a health service that is provided using telemedicine. This coverage must include Landlines, wireless communications, the Internet, telephone networks, and Synchronous or asynchronous transmissions using audio only, video only, audio and video and transmission of data from remote monitoring devices.	Page: _____ Paragraph or Section: _____

Category	Reference	Description of review standards requirements	Page and paragraph
Tobacco use cessation	USPSTF A and B List ORS 743A.170, Definition 45 CFR 147.102	Please review the USPSTF A and B list for requirements related to tobacco use cessation: tobacco use cessation medication, including over the counter medications, must be provided without cost-sharing. Tobacco use is defined as use of tobacco on average four or more times per week within no longer than the past six months. This includes all tobacco products, except that tobacco use does not include religious or ceremonial use of tobacco. Further, tobacco use must be defined in terms of when a tobacco product was last used. For members not subject to USPSTF A and B List coverage, follow the Oregon mandate.	Page: _____ Paragraph or Section: _____
Traumatic brain injury	ORS 743A.175	A policy must cover medically-necessary therapy and services for the treatment of traumatic brain injury	Page: _____ Paragraph or Section: _____
Wigs	OAR 836-053-0012 (3)(c)(B)	following chemotherapy or radiation therapy wigs must be covered up to the actuarial equivalent of \$150 per calendar year Annual dollar limits must be converted to a non-dollar actuarial equivalent	Page: _____ Paragraph or Section: _____
Women's health care	ORS 743B.222, PHSA 2719A, 45 CFR 147.138	Provision permits a female enrollee to designate a women's health care provider as her primary care provider as defined in 743B.222. "women's health care provider" means an obstetrician or gynecologist, physician assistant specializing in women's health, advanced registered nurse practitioner specialist in women's health, naturopathic physician specializing in women's health or certified nurse midwife, practicing within the applicable lawful scope of practice	Page: _____ Paragraph or Section: _____ N/A <input type="checkbox"/>
POLICY PROVISIONS			
Allowable charge methodology	ORS 743B.281, ORS 743B.282, ORS 743B.283, OAR 836-053-1409- OAR 836-053-1415	A written methodology of how allowable charges are determined which complies with all methodology and disclosure requirements defined by law. The plan must establish a process for providing enrollees a reasonable estimate of the cost of services in advance of the procedure.	Page: _____ Paragraph or Section: _____
Annual and lifetime dollar limits prohibited	ORS 743B.013, 45 CFR 147.126, 29 CFR 2590.715- 2711	A small group health benefit plan may not impose annual or lifetime limits on the dollar amount of essential health benefits.	Page: _____ Paragraph or Section: _____

Category	Reference	Description of review standards requirements	Page and paragraph
Arbitration	ORS 36.600 to 36.740, Bulletin 2020-1	Voluntary arbitration is permitted by the Oregon Constitution and statutes. Please see additional details below: <ul style="list-style-type: none"> • 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 <input type="checkbox"/>
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 <input type="checkbox"/>
Balance billing prohibited for in-network healthcare facility services	Bulletin 2022-1, 45 C.F.R § 149.410-440 PHS Act section 2799B-8&9: Federal No Surprises Act	Balance billing is not permitted for services performed by an out of network provider received at an in-network facility and for emergency services	Confirmed <input type="checkbox"/>
Calendar year, contract year and rating period.	ORS 743B.005(23), 45 CFR 156.210	Out-of-pocket provisions define calendar year and contract year.	Page: _____ Paragraph or Section: _____
Cancellation, Nonrenewal And Continuation	Notice upon termination ORS 743B.320 ORS 743B.323 OAR 836-052-0860 ORS 743.495, ORS 743.498	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: <ul style="list-style-type: none"> • 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. <p>Each certificate issued under the policy shall also contain a statement describing the above requirements.</p>	Page: _____ Paragraph or Section: _____

Category	Reference	Description of review standards requirements	Page and paragraph
Cancellation, Nonrenewal And Continuation	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: _____
	State Continuation ORS 743B.347, OAR 836-053-0851-0863	Employers who are not required to make available continuation of health insurance benefits under Titles X and XXII of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) must provide state continuation insurance as defined under Oregon law.	Page: _____ Paragraph or Section: _____
Certifications and disclosure of coverage	ORS 743B.102	All carriers that offer individual or group health benefit plans shall provide certifications and disclosure of coverage in accordance with 42 U.S.C. 300gg(e) and 300gg-43 as amended and in effect on July 1, 1997.	Confirmed <input type="checkbox"/>
Claim 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: _____ N/A <input type="checkbox"/>
	Claim forms ORS 743.426*	The "claim forms" statement in ORS 743.426 or a similar statement is included in the policy	Confirmed <input type="checkbox"/>
Conflict between state and federal law	OAR 836-053-0012(5) OAR 836-053-0004	If both a state law and federal law require coverage of the same or similar service, the insurer must assure that all elements of both laws are met and provide the coverage in the manner most beneficial to the consumer.	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 0806	Coordination of benefits provisions comply with ORS 743B.475 and OAR 836-020-0770 to 0806, and related exhibits. Reduction of benefit payments on the basis of other insurance for the insured individual is in full accordance with coordination-of-benefits rules.	Confirmed <input type="checkbox"/>
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.	Page: _____ Paragraph or Section: _____

Category	Reference	Description of review standards requirements	Page and paragraph
Dependent coverage	Dependents age 26 45 CFR 147.120	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. <i>“Child” means an individual who is under 26 years of age.</i>	Page: _____ Paragraph or Section: _____
	Natural and adopted children ORS 743A.090	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.	
	Domestic partners HB 2032	The Oregon Family Fairness Act (ORS 106.300 to 106.340) recognizes and authorizes domestic partnerships in Oregon. <ul style="list-style-type: none"> • A domestic partnership is defined in ORS 106.310 as “a civil contract entered into in person between two individuals 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. 	Confirmed <input type="checkbox"/>
	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 <input type="checkbox"/> N/A <input type="checkbox"/>
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.	Confirmed <input type="checkbox"/>
Discrimination	ORS 746.015, 45 CFR 146.121	No person shall make or permit any unfair discrimination against participants and beneficiaries based on a health factor or between individuals of the same class and equal expectation of life, or between risks of essentially the same degree of hazard.	Confirmed <input type="checkbox"/>
	OAR 836-080-0055	Distinctions based on sex, sexual orientation, or marital status made in the following matters constitute unfair discrimination: <ol style="list-style-type: none"> (1) The availability of a particular insurance policy. (2) The availability of a particular amount of insurance or set of coverage delimiting factors. (3) The availability of a particular policy coverage or type of benefit, except for those relating to physical characteristics unique to one sex. 	Confirmed <input type="checkbox"/>

Category	Reference	Description of review standards requirements	Page and paragraph
Discrimination	45 CFR 156.200(e), 81 FR 31375, ACA section 1557, 45 CFR Part 92, 45 CFR 146.121	A QHP issuer must not, with respect to its QHP, discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, or sexual orientation	Confirmed <input type="checkbox"/>
	Benefit design 45 CFR 156.125(a)	The benefit design or implementation of benefits is not based on predicated disability, degree of medical dependency, quality of life, or other health conditions	Confirmed <input type="checkbox"/>
	Diethylstilbestrol use by mother ORS 743A.088	Insurers may not deny issuance of a health insurance policy because the mother of the insured used drugs containing diethylstilbestrol prior to the insured's birth.	Confirmed <input type="checkbox"/>
	Gender specific coverage Bulletin 2016-1, OAR 836-10-0155, 42 U.S. Code § 18116	The perceived gender or gender identity of a person should not prevent appropriate treatment required by mandates that are gender specific. Any health care services that are ordinarily or exclusively available to individuals of one sex may not be denied based on the <i>perceived</i> gender or gender identity of a person when the denial or limitation is due only to the fact that the insured is enrolled as belonging to the other sex. Note: Carriers are reminded to use caution when applying gender specific pronouns	Confirmed <input type="checkbox"/>
	Health factors 45 CFR 146.121, 45 CFR 147.110	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 <input type="checkbox"/>
	Providers 42 U.S.C. 300gg-5, PHSA 2706	The policy does not discriminate against providers acting within scope of own licensure or certification.	Confirmed <input type="checkbox"/>
	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.	Page: _____ Paragraph or Section: _____

Category	Reference	Description of review standards requirements	Page and paragraph
Effective dates	ORS 743B.005(23), ORS 743.405(2)	The policy must state the time at which the insurance takes effect and terminates.	Page: _____ Paragraph or Section: _____ N/A <input type="checkbox"/>
	Initial and annual open enrollment periods; and Special enrollment periods 45 CFR 146.117, 45 CFR 155.420, 45 CFR 155.725, OAR 836-053-0211, OAR 836-053-0230	This policy or contract form must provide for an annual open enrollment period, and special enrollment periods, including those special enrollment periods that allow for the addition of a new family member.	Confirmed <input type="checkbox"/>
Eligibility	ORS 743B.470	Eligibility for benefits is not determined based on eligibility for Medicaid.	Confirmed <input type="checkbox"/>
	OAR 836-053-0021(2)(a) 45 CFR §146.121 (b)(1)(i) PHSA 1557	Eligibility is not based on any health status related factors.	Confirmed <input type="checkbox"/>
	Residency Requirements 45 CFR 155.305	On-Exchange: Must be U.S. citizen and resident of Oregon Off-Exchange: No requirement to be a U.S. citizen	Page: _____ Paragraph or Section: _____

Category	Reference	Description of review standards requirements	Page and paragraph
Enrollees covered by workers' compensation	ORS 743B.810 OAR 836-053-0100 OAR 836-053-0105	<p>Requires health benefit plans to provide coverage for claims for covered services denied or not yet adjudicated by the workers' compensation carrier.</p> <p>The plan shall expedite preauthorization's required for, work-related injuries or occupational diseases if:</p> <p>(a) The injured worker is covered by workers' compensation insurance and the health benefit plan; and</p> <p>(b) The injured worker has submitted a workers' compensation claim for the work-related injury or occupational disease that has not been accepted or denied by the workers' compensation carrier.</p> <p>The plan shall guarantee payment for preauthorized medical services to the provider of those medical services according to the terms, conditions and benefits of the plan if the claim is found not to be a compensable workers' compensation claim.</p>	Confirmed <input type="checkbox"/>
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: _____

Category	Reference	Description of review standards requirements	Page and paragraph
Essential health benefit plans	<p>ORS 743B.013, OAR 836-053-0012,</p> <p>PHSA 2711, 42 U.S.C. § 300gg-6(b) 45 CFR 156.110</p> <p>Pediatric Dental OAR 836-053-0012(2)(c)(B) and (f)</p>	<p>The policy must cover at least the following general categories of benefits:</p> <ul style="list-style-type: none"> • Ambulatory patient services • Emergency services • Hospitalization • Maternity and newborn care • Mental health and substance abuse disorder services, including behavioral health treatment • Prescription drugs • Rehabilitative and habilitative services and devices • Laboratory services • Preventive and wellness services and chronic disease management • Pediatric services, including oral and vision care <p>Note: If this policy provides coverage for pediatric dental, it must follow the requirements under Oregon Benchmark (CHIP) plan in our pediatric dental product standard and be certified by the Oregon Health Insurance Marketplace</p>	<p>Page: _____ Paragraph or Section: _____</p>
	<p>Pediatric Vision OAR 836-053-0012(2)(f), 836-053-0012(2)(c)(C) and (g)</p>	<ul style="list-style-type: none"> ○ Eye exam and hardware ○ One exam and lenses every year ○ One frame every two years, subject to maximum benefit <p>“Pediatric vision benefits” means the benefits described in the vision provisions of the Federal Employee Dental and Vision Insurance Plan Blue Vision High Option as set forth on the Insurance Division website. Pediatric vision benefits are payable to persons under 19 years of age.</p> <p><i>Annual dollar limits must be converted to a non-dollar actuarial equivalent.</i></p>	<p>Confirmed <input type="checkbox"/></p>
	<p>Benefits not allowed as EHB’s OAR 836-053-0012(4)</p>	<p>The following may not be included as essential health benefits:</p> <ul style="list-style-type: none"> (a) Routine non-pediatric dental services; (b) Routine non-pediatric eye exam services; (c) Long-term care or custodial nursing home care benefits; or (d) Non-medically necessary orthodontia services. 	<p>Page: _____ Paragraph or Section: _____</p>

Category	Reference	Description of review standards requirements	Page and paragraph
Grace period	ORS 743B.320, 45 CFR 156.270(2)	<p><u>Plans outside the exchange</u> – Policy shall specify a minimum grace period of at least 10 days after the premium due date for the payment of each premium falling due after the first premium, during which grace period the policy shall continue in force.</p> <p><u>Plans inside the exchange</u> - The policy complies with the three month grace period rules established by the exchange. Enrollees who are receiving a tax credit will have coverage for all allowable claims for the first month of the three month grace period and may pend subsequent claims in the second and third month of the grace period.</p>	Page: _____ Paragraph or Section: _____
Grievances, internal appeals and external review	ORS 743B.001	<p>Include the statutory definition for:</p> <ul style="list-style-type: none"> • Adverse benefit determination • Authorized representative • Grievance 	Page: _____ Paragraph or Section: _____
	ORS 743B.250, OAR 836-053-1030, OAR 836-053-1090, OAR 836-053-1110, 45 CFR §147.136	<p>Each insurer must furnish written information to policyholders that is required by ORS 743B.250. The written information must be included either in the policy or in other evidence of coverage that is delivered to the individual policyholder by the insurer or in the case of a group health insurance policy, that is delivered by the insurer to the group policyholder for distribution to enrollees.</p> <p>The carrier must provide assistance in filing written grievances and provide to enrollees information regarding the use of the insurer’s grievance process. A written decision by an insurer in response to a grievance must disclose that the enrollee has a right to file a complaint or seek other assistance from the Insurance Division of the Department of Consumer and Business Services and provide contact the contact information described in OAR 836-053-1030(6).</p>	Page: _____ Paragraph or Section: _____

Category	Reference	Description of review standards requirements	Page and paragraph
Grievances, internal appeals and external review	Internal appeals	The following items must be disclosed in the policy:	
	ORS 742.005 ORS 743B.250, OAR 836-053-1100(1)	<ul style="list-style-type: none"> • 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. 	Page: _____ Paragraph or Section: _____
	External appeals	The insurer must have a process in place for an external review with an Independent Review Organization (IRO) and the following must be disclosed in the policy:	
	ORS 743B.252 OAR 836-053-1030 Bulletin 2020-15 ORS 743B.254 ORS 743B.255	<p>A disclosure that the enrollee may request and receive from the insurer the information the insurer is required to disclose under ORS 743B.250.</p> <p>To ensure transparency and an equitable and uniform approach to this issue, the division instructs insurers to develop and follow a set of written policies and procedures to ensure timely receipt of a signed waiver from an enrollee to enable compliance with the required timelines for the external review process. This set of policies and procedures must be specified in policy forms subject to review by the division, including both a consumer-facing description of the process to get a signed waiver and a document detailing the carrier's internal policies and procedures in this area.</p> <p>Include in the plan the following statements, in boldfaced type or otherwise emphasized:</p> <ol style="list-style-type: none"> 1. A statement of the right of an enrollee to apply for external review by an independent review organization; 2. A statement that an enrollee applying for external review by an independent review organization may be required to authorize the release of any medical records necessary to conduct the external review; and 3. A statement that if the insurer does not follow a decision of an independent review organization, the enrollee has the right to sue the insurer. 	Page: _____ Paragraph or Section: _____

Category	Reference	Description of review standards requirements	Page and paragraph
Grievances, internal appeals and external review	ORS 743B.250, OAR 836-053-1030	<p>Insurers must disclose that the following additional information is available upon request. The procedure to obtain assistance available from the insurer, if any, and from the Department of Consumer and Business Services in filing grievances.</p> <p>Since OID unveiled a new website in early 2014, the URL listed in OAR 836-053-1030(6) is incorrect and must be changed to http://www.oregon.gov/DCBS/insurance/gethelp/Pages/fileacomplaint.aspx.</p> <p>The notice must also include a statement that the following additional information may be available from the Department of Consumer and Business Services:</p> <ul style="list-style-type: none"> • Annual summary of grievance and appeals • Annual summary of utilization review policies • Annual summary of quality assessment activities • Results of all publicly 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 <p>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.</p>	Page: _____ Paragraph or Section: _____
Guaranteed availability	ORS 743B.003, 45 CFR 147.104. 45 CFR 155.420	The policy explains special and open enrollment periods. Issuers may restrict enrollment to open and special enrollment periods and enrollment periods for qualifying events.	Confirmed <input type="checkbox"/>
	OAR 836-053-0050, OAR 836-053-0030(2)	Nongrandfathered plans and plan options are available without regard to health status, claims experience or industry and are offered on a guaranteed issue basis	Confirmed <input type="checkbox"/>
	OAR 836-053-0030(3)	A carrier may not require a small employer to purchase or maintain other lines of coverage, such as group life insurance, in order to purchase or maintain a small employer health benefit plan. However, a small group carrier may require reasonable assurance of pediatric dental coverage consistent with Essential Health Benefits, Final Rule, 78 Fed. Reg. 12853 (February 25, 2013).	Confirmed <input type="checkbox"/>

Category	Reference	Description	Page and paragraph
Guaranteed renewability	ORS 743B.003, 45 CFR 147.106, PHS 2702	<p>The policy guarantees the renewability of insurance coverage in compliance with the federal mandate.</p> <p>An issuer that offers health insurance coverage must renew or continue in force coverage. 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.</p>	Page: _____ Paragraph or Section: _____
	Past due premiums: refusal to enroll	Issuers adopting a premium payment refusal to enroll policy are required to clearly describe, in any enrollment application materials, and in any notice that is provided regarding non-payment of premiums, in paper or electronic form, the consequences of non-payment on future enrollment. Only past due premiums owed to the same carrier may be considered for refusal to enroll.	Confirmed <input type="checkbox"/> N/A <input type="checkbox"/>
Health Savings Accounts	OAR 836-053-0011, SB 1549(2018) ORS 743A.067(10)	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 <input type="checkbox"/>
HIPAA requirements	45 CFR Part 160, 45 CFR Part 164 (Subparts A and E)	Policy meets all HIPAA privacy requirements and all HIPAA-related statements are solely supported by HIPAA requirements.	Confirmed <input type="checkbox"/>
Hospital payment of copayment or deductible for insured patient.	ORS 743B.290	An insurer may not prohibit a hospital, as a condition of reimbursing a claim for hospital services, from paying or waiving all or a portion of a copayment or deductible owed by an insured under the policy or certificate.	Confirmed <input type="checkbox"/>
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: _____ N/A <input type="checkbox"/>
Information to enrollees	ORS 743.406	A group health insurance 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, and the applicable rights and conditions set forth in ORS 743B.340, 743B.341 and 743B.343 to 743B.347. If dependents are included in the coverage, only one statement need be issued for each family unit.	Page: _____ Paragraph or Section: _____

Category	Reference	Description	Page and paragraph
Marketing and benefit design of QHPs (inside exchange only)	45 CFR 156.225, OAR 836-053-0050(4)	A QHP issuer and its officials, employees, agents, and representatives must not employ marketing practices or benefit designs that will have the effect of discouraging the enrollment of individuals with significant health needs in QHPs.	Confirmed <input type="checkbox"/>
Maximum out of pocket	PHSA 2707, 42 U.S. C. § 156.130 ORS 743B.005(23) Calendar year, contract year and rating period.	Health plans must limit out-of-pocket maximums on essential health benefits to the amount described in 42 U.S.C. § 18022 (c)(1)(B). Out-of-pocket provisions define calendar year and contract year. The definition follows your administration of these provisions and clearly states how the crediting for previously satisfied deductibles or out-of-pocket maximum is applied to mid-year contract renewal.	Page: _____ Paragraph or Section: _____
Network adequacy	45 CFR 156.230, ORS 743B.505 Disclosure: ORS 743B.250, OAR 836-053-1030(9), OAR 836-053-0350, OAR 836-053-0300-0350, ORS 742.005, OAR 836-010-0011(3)	A QHP issuer must ensure that the provider network of each of its QHPs, as available to all enrollees, meets the following standards— (1) Includes essential community providers in accordance with 45 CFR 156.235; (2) Maintains a network that is sufficient in number and types of providers, including providers that specialize in mental health and substance abuse services, to assure that all services will be accessible without unreasonable delay; and, (3) Is consistent with the network adequacy provisions of PHSA section 2702(c). For plan years beginning on or after January 1, 2016, a QHP issuer must publish an up-to-date, accurate, and complete provider directory, including information on which providers are accepting new patients, the provider's location, contact information, specialty, medical group, and any institutional affiliations, in a manner that is easily accessible to plan enrollees, prospective enrollees, the State, the Exchange, HHS and OPM. A provider directory is easily accessible when - (i) The general public is able to view all of the current providers for a plan in the provider directory on the issuer's public Web site through a clearly identifiable link or tab and without creating or accessing an account or entering a policy number; and (ii) If a health plan issuer maintains multiple provider networks, the general public is able to easily discern which providers participate in which plans and which provider networks. A QHP issuer must further provide disclosure that provider networks are subject to change at any time based on provider contracting and contracting with a particular provider is subject to change, both in the evidence of coverage as defined in ORS 731.069, and in their web-based provider directories	Confirmed <input type="checkbox"/>

Category	Reference	Description	Page and paragraph
Notification of changes to preventive benefits	45 CFR 147.106, 45 CFR 147.130(b), PHSA 2715, OAR 836-053-0001&2	<p>Only at the time of renewal may issuers modify the health insurance coverage for a product offered to an enrollee.</p> <ul style="list-style-type: none"> • Written notice must be provided to each enrollee in accordance with state and federal law. • 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. • Insurers must provide 60 days' notice to enrollees before material modifications are made to coverage of preventive services under PHSA 2715(d)(4). 	Page: _____ Paragraph or Section: _____
Participation or contribution requirements	ORS 743B.013	A carrier may not deny a small employer's application for coverage under a health benefit plan based on participation or contribution requirements but may require small employers that do not meet participation or contribution requirements to enroll during the open enrollment period.	Page: _____ Paragraph or Section: _____
	ORS 746.240, OAR 836-053-0221	<p>For every group health benefit plan, a carrier that chooses to enforce participation, contribution or eligibility requirements must:</p> <p>(a) Specify in the plan all of participation, contribution, and eligibility requirements that have been agreed upon by the carrier and the group; and</p> <p>(b) Apply the participation and eligibility requirements uniformly to all categories of eligible members and their dependents.</p>	Page: _____ Paragraph or Section: _____
Pediatrician access	PHSA 2719A, 45 CFR 147.138(a)(2)	Requires a non-grandfathered plan that mandates designation of a primary care physician to allow the policyholder to designate any willing in-network pediatrician as a child's primary care physician.	Page: _____ Paragraph or Section: _____ N/A <input type="checkbox"/>
Physical examinations and autopsy	ORS 743.438*	<p>The policy shall contain a similar provision as follows:</p> <p>“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.”</p>	Page: _____ Paragraph or Section: _____ N/A <input type="checkbox"/>

Category	Reference	Description	Page and paragraph
Participation or contribution requirements	ORS 746.240, OAR 836-053-0221(2)	<p>For a small group health benefit plan, a carrier:</p> <ul style="list-style-type: none"> (a) May establish and apply contribution requirements for different categories of members and dependents that exceed the minimum contribution; (b) Must apply participation requirements on an aggregate basis in which all categories of eligible employees of a small employer are combined; (c) Must apply participation and eligibility requirements uniformly to all small employers with the same number of eligible employees; (d) If a carrier requires 100 percent participation of eligible employees in a small group health benefit plan, the carrier may not impose a contribution requirement upon the employer that exceeds 50 percent of the premium of an employee-only benefit plan; and (e) Except as provided above, a carrier may not increase any requirement for minimum employee participation or any requirement for minimum employer contribution applicable to a small employer except at plan anniversary. At plan anniversary, the carrier may increase the requirements only to the extent those requirements are applicable to all other small employer groups of the same size. At the anniversary of a plan or at any time other than the anniversary, a small employer carrier may consider the existing small group as a new group for purposes of coverage if the eligibility requirements applicable to the group are changed by the employer. 	Page: _____ Paragraph or Section: _____
Primary care providers	ORS 743B.250, OAR 836-053-1030(9) ORS 743B.220 SB 1529(2022)	<p>If a plan has a defined network of participating providers it must include a list of:</p> <ul style="list-style-type: none"> • All participating primary care providers; • Direct access providers; and • All specialty care providers. <p>The plan must permit the enrollee to change participating primary care physicians at will, except that the enrollee may be restricted to making changes no more frequently than two times in any 12-month period and may be limited to designating only those participating primary care physicians accepting new patients.</p> <p>An insurer must assign a beneficiary under the policy or certificate to a primary care provider if the beneficiary or a parent of a minor beneficiary has not selected a primary care provider by the 90th day of the plan year. If the insurer assigns the beneficiary to a primary care provider, the insurer shall provide notice of the assignment to the beneficiary or parent and to the primary care provider.</p>	Yes <input type="checkbox"/> N/A <input type="checkbox"/>

Category	Reference	Description	Page and paragraph
Proof of loss	OAR 836-080-0230, OAR 836-080-0235 ORS 743.429*	The policy includes claim procedures and the procedures and timelines comply with fair claim practice requirements. 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.	Page: _____ Paragraph or Section: _____
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 unless disclosed in the policy.	Confirmed <input type="checkbox"/> NA <input type="checkbox"/>
Representations are not warranties	ORS 743.406	A group insurance policy must 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, and that 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.	Page: _____ Paragraph or Section: _____
Rescissions	ORS 743B.013, ORS 743B.310, 45 CFR 147.128, PHSA 2712-0825	Coverage may be rescinded only for fraud or intentional misrepresentation of material fact as prohibited by the terms of the coverage. A plan must provide at least 30 days advance written notice to each participant who would be affected prior to rescinding coverage.	Page: _____ Paragraph or Section: _____
Referrals to specialists	ORS 743B.227	If an insurer requires, as a condition of coverage for specialty care services, a referral by a physician who is authorized under the plan or under the medical services contract between the physician and the insurer to refer an enrollee to specialty care services, the insurer must include the requirements of the listed statute in the plan.	Page: _____ Paragraph or Section: _____
Small group defined	ORS 743B.005, OAR 836-053-0015	"Small employer" means an employer that employed an average of at least one but not more than 50 employees on business days during the preceding calendar year, the majority of whom are employed within this state, and that employs at least one eligible employee on the first day of the plan year.	Page: _____ Paragraph or Section: _____
	Categories of employees ORS 743B.011, OAR 836-053-0021	Different group health plans providing coverage to various categories of employees when the employer has chosen to establish different categories of employees in a manner that does not relate to the actual or expected health status of such employees or their dependents. The categories must be based on bona fide employment-based classifications that are consistent with the employer's usual business practice.	Page: _____ Paragraph or Section: _____

Category	Reference	Description	Page and paragraph
Small group defined	ORS 743B.013(7), OAR 836-053-0221	Describes contribution and participation requirements.	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: _____
Utilization review	ORS 743B.423, OAR 836-053-1030(8), OAR 836-053-1140, ORS 743B.250, HB 2517(2021)	The plan must follow all requirements described in 743B.423 and related requirements. "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: _____
Prior Authorization	ORS 743B.420, ORS 743B.422, ORS 743B.423, OAR 836-053-1200, SB 249(2019), HB 2517(2021)	."Prior authorization" means a determination by an insurer prior to provision of services that the insurer will provide reimbursement for the services <ul style="list-style-type: none"> • Policy describes prior authorization and binding in compliance with the listed statutes as updated by SB 249(2019) and related OARs. • 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: _____
PRESCRIPTION DRUGS			
Prescription drugs	ORS 743A.062 ORS 743A.064	Prescription drug coverage does not exclude coverage of a drug because the drug is not Food and Drug Administration (FDA) approved for a prescribed medical condition if the drug is recognized as effective for the treatment of that indication under the conditions specified in ORS 743A.062. The plan must include coverage for prescription drugs dispensed by a licensed practitioner at a rural health clinic for an urgent medical condition if there is not a pharmacy within 15 miles of the clinic or if the prescription is dispensed for a patient outside of the normal business hours of any pharmacy within 15 miles of the clinic.	Confirmed <input type="checkbox"/>
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 if the requirements of 743A.063 are met.	Confirmed <input type="checkbox"/>

Category	Reference	Description	Page and paragraph
Eye drops	ORS 743A.065	Provides coverage for one early refill of a prescription for eye drops to treat glaucoma under certain conditions provided in statute.	Page: _____ Paragraph or Section: _____
Coverage minimums	45 CFR 156.122	Plans must provide coverage of 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; or 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. The plan must have procedures in place that allow an enrollee to request and gain access to clinically appropriate drugs not covered by the health plan.	Confirmed <input type="checkbox"/>
Drug Formularies	OAR 836-053-1020(8), 45 CFR 156.122, OAR 836-053-1020	<p>An insurer that issues a small group or individual health benefit plan formulary does not comply with the nondiscrimination requirements of OAR 836-053-0012 if most or all drugs to treat a specific condition are placed in the highest cost tier.</p> <p>A plan's formulary must contain an exception process unless the product is using an open formulary.</p> <p>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.</p> <p>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.</p> <p>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.</p>	Confirmed <input type="checkbox"/> N/A <input type="checkbox"/>
Insulin	ORS 743A.069, SB 1508(2024)	Coverage of insulin requires first dollar coverage and out of pocket cost is capped at \$35 for a 30 day supply of a type of prescribed insulin or \$105 for a 90-day supply.	Confirmed <input type="checkbox"/>

Category	Reference	Description	Page and paragraph
Drug Formularies	Open formulary OAR 836-053-1030(2)	<p>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.</p> <p>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.</p>	<p>Confirmed <input type="checkbox"/></p> <p>N/A <input type="checkbox"/></p>
	Mandatory closed formulary ORS 743B.250, OAR 836-053-1020(4), OAR 836-053-1030(11)	<p>If the insurer of a plan uses a mandatory closed formulary, the information for that plan must prominently disclose and explain the formulary provision. The disclosure and explanation must be in boldfaced type or otherwise emphasized.</p> <p>The insurer must also include a written procedure that describes the following:</p> <ul style="list-style-type: none"> • that FDA approved prescription drug products are covered only if they are listed in the formulary. • how the insurer determines the content of the mandatory closed formulary; • how a provider may request inclusion of a new item in the formulary; and • that the insurer will issue a timely written response to a provider making such a request. 	<p>Page: _____ Paragraph or Section: _____ N/A <input type="checkbox"/></p>
	Opioid withdrawal medication ORS 743B.425	<p>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 60 days of treatment and cannot restrict access to in-network pharmacists or pharmacies.</p>	<p>Confirmed <input type="checkbox"/></p>
	Step therapy ORS 743B.602	<p>Requires health benefit plans to provide provider with an explanation of its prescription drug step therapy protocols and the mechanism for seeking override of the protocol</p>	<p>Confirmed <input type="checkbox"/></p> <p>N/A <input type="checkbox"/></p>
	Synchronization plan ORS 743B.601	<p>Requires health benefit plans to provide a means for insureds to synchronize prescriptions.</p>	<p>Confirmed <input type="checkbox"/></p>

Category	Reference	Description	Page and paragraph
PROVIDER REIMBURSEMENT			
Acupuncturist	ORS 743A.020, OAR 836-053-0017	A policy that provides coverage for acupuncture services performed by a physician shall provide coverage for acupuncture services performed by a licensed acupuncturist. This coverage is now an EHB in Oregon and required coverage.	Page: _____ Paragraph or Section: _____ N/A <input type="checkbox"/>
Ambulance payments	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: _____
Chiropractic	OAR 836-053-0017	Chiropractic services are now an EHB and required coverage for all plans.	Confirmed <input type="checkbox"/>
Clinical social worker	ORS 743A.024*	Whenever any individual or group policy provides for payment or reimbursement for any service within the lawful scope of service of a clinical social worker licensed under ORS 675.530: (1) The insured under the policy shall be entitled to the services of a clinical social worker licensed under ORS 675.530, upon referral by a physician or psychologist. (2) The insured under the policy shall be entitled to have payment or reimbursement made to the insured or on behalf of the insured for the services performed. The payment or reimbursement shall be in accordance with the benefits provided in the policy and shall be computed in the same manner whether performed by a physician, by a psychologist or by a clinical social worker, according to the customary and usual fee of clinical social workers in the area served.	Page: _____ Paragraph or Section: _____ N/A <input type="checkbox"/>
Dentist	ORS 743A.032*	Coverage provides reimbursement for any surgical 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 <input type="checkbox"/>
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 <input type="checkbox"/>

Category	Reference	Description	Page and paragraph
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 <input type="checkbox"/>
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: _____
Naturopathic physicians	ORS 743B.407	An insurer shall provide a naturopathic physician the choice of applying to be credentialed by the insurer as a primary care provider or as a specialty care provider.	Page: _____ Paragraph or Section: _____
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. Vision care provider contracts must comply with 743B.406.	Page: _____ Paragraph or Section: _____
Services provided by osteopathic physician	ORS 743A.018	An insurer that offers a health benefit plan that reimburses the cost of an osteopathic manipulative treatment provided by an osteopathic physician shall reimburse the cost of the evaluation conducted by the osteopathic physician that resulted in the osteopathic manipulative treatment.	Page: _____ Paragraph or Section: _____ N/A <input type="checkbox"/>
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; and Shall provide payment or reimbursement for the prescription of emergency refills of insulin and associated insulin-related devices and supplies as described in ORS 689.696. In addition, a pharmacist is also authorized to prescribe, dispense, and administer preexposure prophylactic antiretroviral therapies (PrEP) medications and HIV tests.	Page: _____ Paragraph or Section: _____

Category	Reference	Description	Page and paragraph
Physician assistant	ORS 743A.044	An insurer may not refuse a claim solely on the ground that the claim was submitted by a physician assistant rather than by a supervising physician for the physician assistant.	Page: _____ Paragraph or Section: N/A <input type="checkbox"/>
Professional counselor or marriage and family therapist	ORS 743A.052	If a group health benefit plan, as described in ORS 743B.005, provides for coverage for services performed by a clinical social worker or nurse practitioner, the plan also must cover services provided by a professional counselor or marriage and family therapist licensed under ORS 675.715 to 675.835.	Page: _____ Paragraph or Section: N/A <input type="checkbox"/>
Psychologist	ORS 743A.048	Coverage provides reimbursement for any service that is within the lawful scope of practice of a duly licensed psychologist.	Page: _____ Paragraph or Section: N/A <input type="checkbox"/>
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 <input type="checkbox"/>
Risk sharing	ORS 743B.250, OAR 836-053-1030(10)	If a plan includes risk-sharing arrangements with physicians or other providers, must contain a statement to that effect, including a brief description of risk-sharing in general and must notify enrollees that additional information is available upon request.	Page: _____ Paragraph or Section: N/A <input type="checkbox"/>
BENCHMARK PLANS			
Marketplace	Bronze, Silver and Gold Standard Plans ORS 743B.130 OAR 836-053-0013 HB 3391(2017) SB 1549(2018)	If a carrier offers a health benefit plan in Oregon, the carrier must offer a standard bronze plan and a standard silver plan in each market type and service area in which it operates. In order to participate in the exchange, carriers must also offer a gold standard plan mandated by the exchange.	Confirmed <input type="checkbox"/>

Category	Reference	Description	Page and paragraph
Base benchmark plan	OAR 836-053-0012	<p>All standard plans provide the same benefits as the base benchmark health benefit plan, excluding the 24-month waiting period for transplant benefits. “Base benchmark health benefit plan” means the PacificSource Health Plans Preferred CoDeduct Value 3000 35 70 small group health benefit plan, including prescription drug benefits, as set forth on the Insurance Division website.</p> <p>Standard plan must follow guidelines as provided in the referenced rule.</p> <p>Note: Additionally, standard plan benefits may not exceed the benchmark plan benefits.</p>	Confirmed <input type="checkbox"/>
	Standard plan naming convention: OAR 836-053-0013(4)(a)	<p>The plan name for standard plans must be in the exact naming convention below: “[Name of Issuer]Standard [Bronze/Silver] Plan”</p> <p>The name of insurer may be shortened to an easily identifiable acronym that is commonly used by the insurer in consumer facing publications</p> <p>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.</p>	Confirmed <input type="checkbox"/>
	Copays and coinsurance OAR 836-053-0013(9)	<p>Copays and coinsurance must comply with the following:</p> <p>(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.</p> <p>(b) Subject to the Mental Health Parity and Addiction Equity Act of 2008, 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.</p> <p>(c) Coinsurance for emergency room coverage must be waived if a patient is admitted. Inpatient coinsurance applies if covered person is admitted.</p>	Page: _____ Paragraph or Section: _____

Category	Reference	Description	Page and paragraph
Base benchmark plan	Deductibles OAR 836-053-0013(10)	Deductibles must comply with the following: <ul style="list-style-type: none"> 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 provided in Exhibit 1 to this rule. 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 provided in Exhibit 2 to this rule. The individual deductible applies to all enrollees, and the family deductible applies when multiple family members incur claims.	Page: _____ Paragraph or Section: _____
	Dollar limits OAR 836-053-0013(11)	Annual dollar limits and lifetime dollar limits must be converted to a non-dollar actuarial equivalent.	Confirmed <input type="checkbox"/>
	Prescription drugs OAR 836-053-0013(8)	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 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). 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. 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.	Confirmed <input type="checkbox"/>
Provider Network	Provider directory 45 CFR 156.230(b), ORS 743B.505, OAR 836-053-0350	A QHP issuer must make its provider directory for a QHP available to the exchange for publication online in accordance with guidance from the exchange and to potential enrollees in hard copy upon request. In the provider directory, a QHP issuer must identify providers that are not accepting new patients.	Confirmed <input type="checkbox"/> N/A <input type="checkbox"/>
Termination rules established by the exchange	45 CFR 155.430, 45 CFR 156.270 (inside exchange only)	The policy complies with termination rules established by the exchange. If member requests termination, reasonable written notice is provided within 14 days from the requested termination date. If the QHP terminates a plan for any reason, a minimum notice of 30 days prior to the last day of coverage is required.	Page: _____ Paragraph or Section: _____ N/A <input type="checkbox"/>
Waiting periods	ORS 743B.013(2), Late enrollees	Late enrollees in a small employer health benefit plan may be subjected to a group eligibility waiting period that does not exceed 90 days.	Confirmed <input type="checkbox"/>
	OAR 836-053-0021(1)(b), PHSA 2708	Waiting periods for enrollment is defined as beginning on the date the employee becomes a qualifying employee and must not exceed 90 days. A single, uniform requirement must apply to all employees of the employer.	Page: _____ Paragraph or Section: _____