Department of Consumer and Business Services
Division of Financial Regulation
350 Winter St. N.E.
P.O. Box 14480
Salem, Oregon 97309-0405
Phone (503) 947-7983

Standard Provisions for Individual 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, including new state and federal regulation 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.

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Insurer name: _____ **Requested effective date:** _____

TOI (type of insurance):	☐	H16I	Individual Health - Major Medical
Sub TOI:	☐	H16I.005A	Individual - Preferred Provider (PPO)
	☐	H16I.005B	Individual – Point of Service (POS)
	☐	H16I.005C	Individual – Other
	☐	H16I.005D	Individual – EPO
Type of carrier	☐	Health insurer	☐ Health Care Service Contractor

***** *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: http://dfr.oregon.gov/rates-forms/health/Pages/health.aspx 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 ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
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 ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
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 ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

Category	Reference	Description of review standards requirements	Answer
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 ☐
Cover page	ORS 742.023, ORS 743.405, ORS 743.492, OAR 836-010-0011	1. The full corporate name of the insuring company appears prominently on the first page of the policy. 2. A marketing name or insurer 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 appear 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 ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
Form numbers	ORS 743.405(7), OAR 836-010-0011	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 ☐
Variability in forms	ORS 742.003, ORS 742.005(2)	Variable material in forms will only be permitted if it is clearly identified by brackets along with a complete explanation of when each would be used. 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. **Note:** Variability guideline instructions are found at: http://dfr.oregon.gov/rates-forms/Documents/health-variability-guidelines.pdf	Yes N/A ☐ ☐

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 *Standards for Health Applications* (Form 440-2442H).	Yes ☐ N/A ☐
Assumption certificates	Form 440-3637	File under *Changes to Business Operations that Require a Filing* (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 *Modification and Discontinuance of Health Benefit Plans* (Form 440-2896) when making a uniform modification or discontinuing a plan. **Note:** modifications and discontinuances can be submitted either in this form filing or as a separate filing. Within the filing, please identify which of the following notices will be used: State or Federal.	Yes ☐ N/A ☐
Pediatric dental embedded in the medical form	Form 440-4978	If pediatric dental is embedded in the individual medical policy, please also submit *Standard Provisions for Exchange Certified Pediatric Dental (ACA compliant) Forms* (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 ☐ N/A ☐
Third Party Payments	45 CFR 156.1250	Carriers must accept payments from third parties as described in 45 CFR 156.1250	Yes ☐ N/A ☐

Benefit Reimbursement			
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.	Page: _____ Paragraph or Section: _____ N/A ☐
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	Answer
Colorectal cancer screenings and laboratory tests	ORS 743A.124	Provide coverage for all colorectal cancer screening examinations and laboratory tests assigned either a grade of A or a grade of B by the United States Preventive Services Task Force. For members aged 50 and older, an insurer may not impose cost sharing on the colorectal cancer screening, examinations and lab tests and must cover, at a minimum: • Fecal occult blood tests (**note**: colonoscopies following a positive fecal test assigned a grade of A or B by the USPSTF must still be provided without cost sharing) • Colonoscopies, including the removal of polyps during a screening procedure; or • Double contrast barium enemas. If an insured is at high risk for colorectal cancer, the required coverage shall include colorectal cancer screening examinations and laboratory tests as recommended by the treating physician.	Page: _____ Paragraph or Section: _____
Contraceptives	ORS 743A.066, ORS 743A.067, PHSA 2713, 45 CFR 147.130, 42 U.S. Code § 300gg–13 HRSA Guidelines	HRSA Guidelines require coverage, without cost sharing, for all Food and Drug Administration (FDA) approved contraceptive methods, sterilization procedures, and patient education and counseling for all persons with reproductive capacity, as prescribed by a provider. Plan must reimburse health care provider or dispensing entity for a dispensing of a contraceptive indented to last for: • A three month period for the first dispensing of the contraceptive to an insured. • A twelve month period for subsequent dispensing of the same contraceptive to the insured regardless of whether the insured was enrolled in the program, plan or policy at the time of the first dispensing. • Over the counter contraceptive must be covered in accordance with ORS 743A.067(2)(j)(c).	Page: _____ Paragraph or Section: _____

Category	Reference	Description of review standards requirements	Answer
Contraception prescribed by pharmacists	ORS 743A.066 ORS 689.005 ORS 689.683 HB 2879(2015) HB 2527(2017)	Contraceptive benefit allows a pharmacist to prescribe and dispense hormonal contraceptive patches and self-administered oral hormonal contraceptives within limits described in HB 2879 and HB 2527. Contraceptive benefit allows a pharmacist to: • Prescribe and dispense hormonal contraceptive patches and self-administered oral hormonal contraceptives within limits described in HB 2879. • Prescribe and administer injectable hormonal contraceptives within the limits prescribed in HB 2527	Page: _____ Paragraph or Section: _____
Confidential Communication Request	ORS 743B.005, ORS 743B.250, ORS 743B.555	Confidential communication request means a request from an enrollee to a carrier or third party administrator that communications be sent directly to the enrollee and that the carrier or third party administrator refrain from sending communications concerning the enrollee to the policyholder or certificate holder Confidential communication request must be made available to members.	Confirmed ☐
Craniofacial anomaly treatment	ORS 743A.150	A policy shall provide coverage for dental and orthodontic services for the treatment of craniofacial anomalies if the services are medically necessary to restore function.	Page: _____ Paragraph or Section: _____
Gestational diabetes	743A.067	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.	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 ☐

Category	Reference	Description of review standards requirements	Answer
Emergency Services, continued	ORS 743A.012(1)(2), 45 CFR §147.138	Health benefit plans shall provide coverage without prior authorization for emergency services. • "Behavioral health assessment" means an evaluation by a behavioral health clinician, in person or using telemedicine, to determine a patient's need for immediate crisis stabilization. • "Behavioral health clinician" means a licensed psychiatrist, psychologist, certified nurse practitioner with a specialty in psychiatric mental health, clinical social worker, professional counselor or licensed marriage and family therapist, certified clinical social work associate, an intern or resident who is working under a board-approved supervisory contract in a clinical mental health field, or any other clinician whose authorized scope of practice includes mental health diagnosis and treatment. • "Behavioral health crisis" means a disruption in an individual's mental or emotional stability or functioning resulting in an urgent need for immediate outpatient treatment in an emergency department or admission to a hospital to prevent a serious deterioration in the individual's mental or physical health • "Emergency medical condition" means a medical condition: o That manifests itself by acute symptoms of sufficient severity, including severe pain, that a prudent layperson possessing an average knowledge of health and medicine would reasonably expect that failure to receive immediate medical attention would: (i) Place the health of a person, or an unborn child in the case of a pregnant woman, in serious jeopardy; (ii) Result in serious impairment to bodily functions; or (iii) Result in serious dysfunction of any bodily organ or part;	Page: _____ Paragraph or Section: _____ N/A ☐

Category	Reference	Description of review standards requirements	Answer
Emergency Services, continued	ORS 743A.012(1)(2), 45 CFR §147.138	o With respect to a pregnant woman who is having contractions, for which there is inadequate time to effect a safe transfer to another hospital before delivery or for which a transfer may pose a threat to the health or safety of the woman or the unborn child**;** or o That is a behavioral health crisis. • "Emergency medical screening exam" means the medical history, examination, ancillary tests and medical determinations required to ascertain the nature and extent of an emergency medical condition. • "Emergency services" means with respect to an emergency medical condition. o An emergency medical screening exam or behavioral health assessment that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition; and o Such further medical examination and treatment as are required under 42 U.S.C. 1395dd to stabilize a patient, to the extent the examination and treatment are within the capability of the staff and facilities available at a hospital.	
Emergency services - Nonparticipating providers	ORS 743A.012(3)(b), 45 CFR §147.138 ORS 743B.287	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 ☐

Category	Reference	Description of review standards requirements	Answer
Emergency services - Information to enrollees	ORS 743A.012(4)(5) ORS 743B.250 OAR 836-053-1030	Health benefit plans shall provide information to enrollees in plain language regarding: a) What constitutes an emergency medical condition; b) The coverage provided for emergency services; c) How and where to obtain emergency services; and d) The appropriate use of 9-1-1. An insurer may not discourage appropriate use of 9-1-1 and may not deny coverage for emergency services solely because 9-1-1 was used.	Page: _____ Paragraph or Section: _____ N/A ☐
Gender Dysphoria	ORS 742.005(4), ORS 746.015(1), ORS 743A.168, OAR 836-053-1404, OAR 836-053-1405, Bulletin 2014-1, Bulletin 2016-1	• Health insurance plans cannot discriminate against people on the basis that the treatment is for gender identity issues. • Gender Dysphoria is a condition defined in the DSM-V and must be covered in compliance with Oregon Bulletin 2016-1. • A health insurer may not categorically exclude coverage for a particular gender-affirming treatment, if the treatment is the only medically necessary treatment available for the person. This includes categorical exclusions such as an exclusion for cosmetic surgery if the treatment is deemed medically necessary for the mental condition of gender dysphoria. Nor may the insurer establish such a broad categorical exclusion or impose utilization controls so there is no viable treatment covered for the insured's condition.	Page: _____ Paragraph or Section: _____
Gender Specific Contract Language	OAR 836-010-0155	An individual's attending provider determines whether a sex-specific recommended preventive service that is required to be covered without cost sharing under section 2713 of the Public Health Service Act and its implementing regulations is medically appropriate for a particular individual. When an attending provider determines that a recommended service is medically appropriate for an individual and the individual satisfies the criteria for the service or treatment, the insurer must provide coverage for the recommended service regardless of sex assigned at birth, gender identity, or gender of the individual otherwise recorded by the insurer.	Page: _____ Paragraph or Section: _____

Category	Reference	Description of review standards requirements	Answer
Hearing aids and hearing care treatment	ORS 743A.141, HB 4104(2018), OAR 836-053-0012	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).	Page: _____ Paragraph or Section: ☐
Oregon Universal Newborn Nurse Home Visiting Program	SB 526	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 ☐
Mammograms	ORS 743A.100 ORS 743A.067 42 USC § 300gg-13 45 CFR §147.130 HRSA Guidelines	Coverage provides for mammograms for the purpose of diagnosis in symptomatic or high-risk women at any time upon referral of the woman's health care provider and an annual mammogram for the purpose of early detection for a woman 40 years of age or older, with or without referral from the woman's health care provider. Note: Preventive mammograms covered without coinsurance are required for members aged 40 and older.	Page: _____ Paragraph or Section: _____

Category	Reference	Description of review standards requirements	Answer
Mastectomy-related services	ORS 743A.110, 42 U.S.C. § 300gg–27 Women's Health and Cancer Rights Act of 1998	Coverage provides reimbursement for mastectomy-related services that are part of the enrollee's course of treatment including all stages of reconstruction with a single determination of prior authorization. The enrollee must be provided a written notice at time of enrollment and annually thereafter describing the coverage for all mastectomy-related services. Include the definition of mastectomy in the contract.	Page: _____ Paragraph or Section: _____
Maxillofacial prosthetic service	ORS 743A.148	Coverage includes maxillofacial prosthetic services considered necessary for adjunctive treatment.	Page: _____ Paragraph or Section: _____
Mental or Nervous Conditions and Chemical Dependency	ORS 743A.168, ORS 743A.190, OAR 836-053-1403to 1408 Bulletin 2014-1, Bulletin 2014-2 29 CFR §2590.712, 45 CFR §146.136, 45 CFR §147.160	All plans include coverage for mental or nervous conditions and chemical dependency, including alcohol. • 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	Answer
Newborns and mothers	ORS 743B.195, 45 CFR 148.170, 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	ORS 743A.068	The policy provides coverage for oral anticancer medication on a basis no less favorable than intravenously administered or injected medications.	Page: _____ Paragraph or Section: _____
Pelvic and Pap smear examinations	ORS 743A.104	Coverage provides reimbursement for pelvic and Pap smear exams provided annually for individuals 18 to 64 and any time upon referral of the woman's health care provider.	Page: _____ Paragraph or Section: _____
Pervasive developmental disorder	ORS 743A.190, 45 CFR 156.125 45 CFR 146.136 45 CFR 156.125, Bulletin 2014-1&2	Pervasive Developmental Disorders (PDD) are mental health conditions and subject to all requirements of federal and state mental health parity laws. • 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 inpatient and outpatient habilitative services and devices. • Bulletin 2014-2 contains additional coverage requirements for Applied Behavior Analysis (ABA) therapy.	Page: _____ Paragraph or Section: _____
Physical breast examinations	ORS 743A.108	Coverage includes a complete and thorough physical examination of the breast	Page: _____ Paragraph or Section: _____

Category	Reference	Description of review standards requirements	Answer
Pregnancy and childbirth expenses	ORS 743A.080, OAR 836-053-0003	Pregnancy care means the care necessary to support a healthy pregnancy and care related to labor and delivery. • Plans must provide payment or reimbursement for expenses associated with pregnancy care and childbirth. • Benefits provided under this section shall be extended to all enrollees, enrolled spouses, and enrolled dependents. • A carrier may not impose an exclusion period or a waiver in a health benefit plan for pregnancy and childbirth expenses, for which coverage is required by ORS 743A.080.	Page: _____ Paragraph or Section: _____
Preventive Services	ORS 743A.262 42 U.S.C. 300gg-13, 45 CFR 147.130 ORS 743A.067 HB 3391(2017) OAR 836-053-0435 (proposed)	Plans must provide coverage of preventive health services, as listed below, and may not impose cost-sharing requirements for preventive services, except as allowed by law. • Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force • Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention • Evidence-informed preventive care and screenings for infants, children, and adolescents supported by the Health Resources and Services Administration (HRSA) In addition, preventive care and screenings as defined in ORS 743B.067 and HB 3391(2017) • **A and B list for preventive services:** https://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/ • **Women's preventive services**: http://www.hrsa.gov/womensguidelines/ **Note**: For enrollees who do not have Internet access, the insurer must provide a phone number where the information available online will be described. Health benefit plans must provide coverage for well-woman preventive visits as described on pages 147 through 151 of the Women's Preventive Service Initiative Report,published December 2016 and available at: http://dfr.oregon.gov/business/insurance-industry/health-ins-regulation/Pages/regulatory-guid.aspx.	Page: _____ Paragraph or Section: _____

Category	Reference	Description of review standards requirements	Answer
Preventive Services (continued)	ORS 743A.262 42 U.S.C. 300gg-13, 45 CFR 147.130 ORS 743A.067 HB 3391(2017) OAR 836-053-0435 (proposed)	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: (a) On the insurer's website; and (b) In writing upon request by an enrollee or potential enrollee.	
Tobacco use cessation	**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.	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 ☐

POLICY PROVISIONS			
Category	Reference	Description of review standards requirements	Answer
Allowable charge methodology	ORS 743B.281 ORS 743B.282 ORS 743B.283	A written methodology of how allowable charges are determined which complies with all methodology and disclosure requirements defined by law.	Page: _____ Paragraph or Section: _____
Annual and lifetime dollar limits prohibited	ORS 743B.125, 45 CFR 147.126, 29 CFR 2590.715-2711	An individual health benefit plan may not impose annual or lifetime limits on the dollar amount of essential health benefits.	Page: _____ Paragraph or Section: _____
Arbitration	ORS 36.600 to 36.740	Voluntary arbitration is permitted by the Oregon Constitution and statutes. Please see additional details below: • Either party may elect arbitration at the time of the dispute (after the claimant has exhausted all internal appeals if applicable); • Unless there is mutual agreement to use an arbitration process, the decision will only be binding on the party that demanded arbitration; • Arbitration will take place in the insured's county or at another agreed upon location; • Arbitration will take place according to Oregon law, unless Oregon law conflicts with Federal Code. • The process may not restrict the injured party's access to other court proceedings; • Restricting participation in a class action suit is permissible.	Page: _____ Paragraph or Section: _____ N/A ☐
Attorney Fees	ORS 742.061	The policy may not include a provision that eliminates access to attorney fees in a dispute between the carrier and the policyholder	Page: _____ Paragraph or Section _____
Balance billing prohibited for in-network healthcare facility services	ORS 743B.287 HB 2339(2017) HB 1549(2018)	Balance billing is not permitted for services performed by an out of network provider received at an in-network facility.	Confirmed ☐

Category	Reference	Description of review standards requirements	Answer
Beneficiaries	ORS 743.444*	If the policy includes a provision for beneficiaries, the policy must include language from ORS 743.444 or equivalent.	Page: _____ Paragraph or Section: _____ N/A ☐
Cancellation and nonrenewal	ORS 743.495, ORS 743.498, ORS 743B.323, ORS 743B.330, OAR 836-053-0415	A noncancelable or guaranteed renewable policy includes a statement from ORS 743.498 or similar language in the policy, explaining the guaranteed or cancelable periods. A separate notice of cancellation must be mailed 10 days prior to the end of the grace period.	Page: _____ Paragraph or Section: _____
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: _____
	Claim forms ORS 743.426*	The "claim forms" statement in ORS 743.426 or a similar statement is included in the policy	Page: _____ Paragraph or Section: _____ N/A ☐
	Notice of claim ORS 743.423(1)*	The "notice of claims" statement in ORS 743.423(1) or a similar statement is included in the policy.	Page: _____ Paragraph or Section: _____
	Payment of claims ORS 743.435*	The "payment of claims" statement in ORS 743.435 or a similar statement is included in the policy	Page: _____ Paragraph or Section: _____
	Time of payment of claims ORS 743.432*	A "time of payment of claims" statement similar to that in ORS 743.432 is included in the policy.	Page: _____ Paragraph or Section: _____
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.	Confirmed ☐

Category	Reference	Description of review standards requirements	Answer
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.	Page: _____ Paragraph or Section: _____
Dependent coverage	ORS 743B.470	An insurer may not deny enrollment of a child under the health plan of the child's parent on the ground that: (a) The child was born out of wedlock; (b) The child is not claimed as a dependent on the parent's federal tax return; or (c) The child does not reside with the child's parent or in the insurer's service area.	Confirmed ☐
	Dependents age 26 45 CFR 147.120 **Natural and adopted children** ORS 743A.090	Plans that provide dependent coverage must extend coverage to adult children up to age 26. Plans are not required to cover children of adult dependents. *"Child" means an individual who is under 26 years of age.* Policy covers natural children of the insured and/or qualified eligible dependents from the moment of birth. Covers adopted children of the insured from the date of placement of the children with the insured for adoption.	Page: _____ Paragraph or Section: _____
	Domestic partners ORS 106.300 to ORS 106.340, Bulletin 2008-2	The Oregon Family Fairness Act (ORS 106.300 to 106.340) recognizes and authorizes domestic partnerships in Oregon. • A domestic partnership is defined in ORS 106.310 as "a civil contract entered into in person between two individuals of the same sex who are at least 18 years of age, who are otherwise capable and at least one of whom is a resident of Oregon." • Any time that coverage is extended to a spouse it must also extend to a domestic partner under conditions no more restrictive than are offered to a married spouse.	Page: _____ Paragraph or Section: _____

Category	Reference	Description of review standards requirements	Answer
Dependent coverage	**Same-sex marriages performed in other states** OAR 836-010-0150	Oregon recognizes the marriages of same-sex couples validly performed in other jurisdictions to the same extent that they recognize other marriages validly performed in other jurisdictions.	Confirmed ☐
Discretionary clauses	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 ☐ N/A ☐
Discrimination	ORS 746.015 45 CFR 146.121	No person shall make or permit any unfair discrimination between individuals of the same class and equal expectation of life, or between risks of essentially the same degree of hazard	Confirmed ☐
	OAR 836-080-0055	Distinctions based on sex, sexual orientation, or marital status made in the following matters constitute unfair discrimination: (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 ☐
	45 CFR 156.200(e) 81 FR 31375 ACA section 1557	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 ☐
	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 ☐
	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 ☐
	Unmarried women and their children ORS 743A.084	The policy does not discriminate between married and unmarried women or between children of married and unmarried women.	Confirmed ☐

Category	Reference	Description of review standards requirements	Answer
Discrimination (continued)	**Health factors** 45 CFR 146.121, 45 CFR 147.110 45 CFR 148.180	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. This term also encompasses source of injury exclusions, including riots, service in the armed forces, and high risk sports. These exclusions are prohibited.	Confirmed ☐
	Gender specific coverage Bulletin 2016-1 OAR 836-010-0155 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 *perceived* 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 ☐
	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 ☐
Effective dates	ORS 743.405(2)	The policy must state the time at which the insurance takes effect and terminates.	Page: _____ Paragraph or Section: _____
	45 CFR 155.410, 45 CFR 155.420, 45 CFR 155.305, OAR 836-053-0431	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.	Page: _____ Paragraph or Section: _____ N/A ☐
	ORS 743B.423, ORS 743B.420, OAR 836-053-1200	Policy describes prior authorization and binding periods. A provider request for prior authorization of nonemergency service must be answered within two business days.	Page: _____ Paragraph or Section: _____

Category	Reference	Description of review standards requirements	Answer
Eligibility	ORS 743B.470	Eligibility for benefits is not determined based on eligibility for Medicaid.	Confirmed ☐
	OAR 836-053-0431, ORS 743B.126 743B.103 PHSA 1557	Eligibility is not based on any health status related factors.	Confirmed ☐
	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	Confirmed ☐
Entire contract	ORS 742.016, ORS 743.411*	The "entire contract" statement in ORS 743.411 or similar statement is included in the policy, explaining that the contract, including the endorsements and attached papers, if any, constitutes the entire contract of insurance.	Page: _____ Paragraph or Section: _____
Entire money	ORS 743.405(1)	The policy must include a statement of the entire money and other considerations due.	Page: _____ Paragraph or Section: _____
Essential health benefit plans	ORS 743B.125, ORS 743B.013 ORS 731.097 OAR 836-053-0012, PHSA 2711, 42 U.S.C. § 300gg–6(b) 45 CFR 156.110 **Pediatric Dental** OAR 836-053-0012(2)(c)(B)	The policy must cover at least the following general categories of benefits: • 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 **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.	Page: _____ Paragraph or Section: _____

Category	Reference	Description of review standards requirements	Answer
Essential Health Benefit Plans	**Pediatric Vision** OAR 836-053-0012(2)(c)(C) OAR 836-053-0012(2)(g)	o Eye exam and hardware o One exam and lenses every year o One frame every two years, subject to maximum benefit "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. ***Annual dollar limits must be converted to a non-dollar actuarial equivalent.***	Page: _____ Paragraph or Section: _____
	Benefits not allowed as EHB's OAR 836-053-0012(4)	The following may not be included as essential health benefits: (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.	Confirmed ☐
Grace period	ORS 743.417, ORS 743B.323 45 CFR 156.270(2)	Plans outside the exchange – 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. Plans inside the exchange - 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.	Page: ☐ Paragraph or Section: _____
Grievances, internal appeals and external review	ORS 743B.001	Include the statutory definition for: • Adverse benefit determination • Authorized representative • Grievance	Page: _____ Paragraph or Section: _____

Category	Reference	Description of review standards requirements	Answer
Grievances, internal appeals and external review (continued)	ORS 743B.250, OAR 836-053-1030, 45 CFR §147.136	Each insurer must furnish written information to policyholders that is required by ORS 743B.250. 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.	Page: _____ Paragraph or Section: _____
	Internal appeals	**The following items must be disclosed in the policy:**	
	ORS 742.005, ORS 743B.250, OAR 836-053-1100	• The plan includes a grievance process as required by state law. • The plan includes proper adverse benefit determination and IRO requirements per state law. • Information on the grievance process is explained in the policy and certificate.	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	A disclosure that the enrollee may request and receive from the insurer the information the insurer is required to disclose under ORS 743B.250.	Page: _____ Paragraph or Section: _____

Category	Reference	Description of review standards requirements	Answer
Grievances, internal appeals and external review (continued)	**Additional information upon request** ORS 743B.250, OAR 836-053-1030(12)	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 https://dfr.oregon.gov/help/complaints-licenses/Pages/file-complaint.aspx. The notice must also include a statement that the following additional information may be available from the Department of Consumer and Business Services: • Annual summary of grievance and appeals • Annual summary of utilization review policies • Annual summary of quality assessment activities • Results of all publically available accreditations surveys • Annual summary of the insurer's health promotion and disease prevention activities • Annual summary of scope of network and accessibility of services	Confirmed ☐
Guaranteed availability	ORS 743B.005, 45 CFR 155.420 45 CFR 147.104	The policy explains special and open enrollment periods. Issuers may restrict enrollment to open and special enrollment periods and enrollment periods for qualifying events.	Page: _____ Paragraph or Section: ☐
	Annual open enrollment period	November 1, 2018-December 15, 2018	Confirmed ☐
Guaranteed issue	ORS 743B.003, OAR 836-053-0431(1)	A carrier must offer all of its approved nongrandfathered individual health benefit plans (that are not closed) and plan options, including individual plans offered through associations, to all individuals eligible for such plans on a guaranteed issue basis without regard to health status, age, immigration status or lawful presence in the United States.	Confirmed ☐
	OAR 836-053-0431(2)(b)	A carrier must enroll an individual who, within 60 days before application for coverage with the carrier: • Loses minimum essential coverage. Loss of minimum essential coverage does not include termination or loss due to failure to pay premiums or rescission as specified in 45 CFR 147.128. The effective date of coverage for the loss of minimum essential must be consistent with the requirements of 45 CFR 155.420(b)(1).	Confirmed ☐

Category	Reference	Description of review standards requirements	Answer
Guaranteed issue	OAR 836-053-0431(2)(b)	• Gains a dependent or becomes a dependent through marriage, birth, adoption or placement for adoption or foster care. The effective date for coverage for enrollment under this paragraph must be: o For marriage, no later than the first day of the first calendar month following the date the carrier receives the request for special enrollment. o For birth, on the date of birth. o For adoption or placement for adoption or foster care, no later than the date of adoption or placement for adoption or foster care. • Experiences a qualifying event as defined under section 603 of the Employee Retirement Income Security Act of 1974, as amended. • Experiences an event described in 45 CFR 155.420(d)(4), (5), (6), or (7).	Confirmed ☐
	Permissible reasons to deny enrollment OAR 836-053-0431(2)(a)	A carrier must deny enrollment under the following circumstances: (A) To an individual who is not lawfully present in the United States in a plan provided through the exchange. (B) To an individual entitled to benefits under a Medicare plan under part A or B or a Medicare Choice or Medicare Advantage plan described in 42 USC 1395W–21, if and only if the individual is enrolled in such a plan.	Confirmed ☐
Guaranteed renewability	ORS 743B.003, ORS 743B.125, 45 CFR 147.106 PHSA 2702	The policy guarantees the renewability of insurance coverage in compliance with the federal mandate. An issuer that offers health insurance coverage must renew or continue in force coverage. An issuer may only non-renew in the event of nonpayment of premiums, fraud, violation of participation or contribution rates, market exit, movement outside the service area, or cessation of association membership.	Page: _____ Paragraph or Section: _____
Health Savings Accounts	OAR 836-053-0011	If a plan or product is HSA eligible under applicable federal law, the insurer or health care service contractor shall clearly indicate on any applicable plan and benefits template or other plan or product specific filing document that the plan is HSA eligible.	Confirmed ☐

Category	Reference	Description of review standards requirements	Answer
HIPAA requirements	ORS 743B.003 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 ☐
Incontestability	ORS 743.414(3)*	The policy contains a provision similar to: "After this policy has been in force for a period of two years during the lifetime of the insured (excluding any period during which the insured is disabled), it shall become incontestable as to the statements contained in the application."	Page: _____ Paragraph or Section: _____
Inducements not specified in policy	ORS 746.035	Except as otherwise expressly provided by the Insurance Code, no person shall permit, offer to make or make any contract of insurance, or agreement as to such contract, unless all agreements or understandings by way of inducement are plainly expressed in the policy issued thereon.	Page: _____ Paragraph or Section: _____ N/A ☐
Legal actions	ORS 743.441*	Provision states that no action at law or in equity is brought to recover on this policy prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the policy. No action shall be brought after the expiration of three years after the time written proof of loss is required.	Page: _____ Paragraph or Section: _____
Marketing and benefit design of QHPs (inside exchange only)	45 CFR 156.225	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 ☐
Maximum out of pocket	PHSA 2707, 45 CFR 156.130(a) ORS 743B.005(23) Calendar year, contract year and rating period.	For 2015, individual 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: _____

Category	Reference	Description of review standards requirements	Answer
Network adequacy	45 CFR 156.230, PHSA 2702(c) OAR 836-053-0300 to-0350	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). 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. **Out-of-network cost sharing.** Beginning for the 2018 and later benefit years, for a network to be deemed adequate, each QHP that uses a provider network must: (1) Notwithstanding § 156.130(c), count the cost sharing paid by an enrollee for an essential health benefit provided by an out-of-network ancillary provider in an in-network setting towards the enrollee's annual limitation on cost sharing; or (2) Provide a written notice to the enrollee by the longer of when the issuer would typically respond to a prior authorization request timely submitted, or 48 hours before the provision of the benefit, that additional costs may be incurred for an essential health benefit provided	Confirmed ☐

Category	Reference	Description of review standards requirements	Answer
Notification of changes to preventive benefits	45 CFR 147.106, 45 CFR 147.130(b), PHSA 2715, OAR 836-053-0001&2	Only at the time of renewal may issuers modify the health insurance coverage for a product offered to an enrollee. • 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: _____
Participating providers	ORS 743B.250, OAR 836-053-1030(9)	If a plan has a defined network of participating providers, must include a list of • All participating primary care providers • Direct access providers and; • All specialty care providers. **Note:** This may be provided to insureds through a webpage, as providers may change frequently.	Yes ☐ N/A ☐
Pediatrician access	PHSA 2719A 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 ☐
Physical examinations and autopsy	ORS 743.438*	The policy shall contain a similar provision as follows: "PHYSICAL EXAMINATIONS AND AUTOPSY: The insurer at its own expense shall have the right and opportunity to examine the person of the insured when and as often as it may reasonably require during the pendency of a claim hereunder and to make an autopsy in case of death where it is not forbidden by law."	Page: _____ Paragraph or Section: _____ N/A ☐
Proof of loss	OAR 836-080-0230, OAR 836-080-0235	The policy includes claim procedures and the procedures and timelines comply with fair claim practice requirements.	Page: _____ Paragraph or Section: ☐

Category	Reference	Description of review standards requirements	Answer
Proof of loss	ORS 743.429*	The "Proof of Loss" statement in ORS 743.429 or a similar statement that proof of loss is due to the insurer within 90 days of the loss or, in the case of continuing loss for which the insurer is obligated to make periodic payments, 90 days after the end of the period of insurer liability. If it is not reasonably possible for the policyholder to meet this requirement, the claim shall not be invalidated or reduced if proof of loss is provided as soon as is reasonably possible and not later than one year after the date proof is otherwise required, except in the absence of legal capacity.	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 ☐ N/A ☐
Rescissions	ORS 743B.125, ORS 743B.310, OAR 836-053-0830, 45 CFR 147.128, PHSA 2712	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: _____
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	Utilization review requirements (prior authorization and appeal process). **OR** “Utilization review” means a set of formal techniques used by an insurer or delegated by the insurer designed to monitor the use of or evaluate the medical necessity, appropriateness, efficacy or efficiency of health care services, procedures or settings.	Page: _____ Paragraph or Section: _____

Category	Reference	Description of review standards requirements	Answer
Prior Authorization	ORS 743B.420, ORS 743B.423, OAR 836-053-1200	"Prior authorization" means a determination by an insurer prior to provision of services that the insurer will provide reimbursement for the services • Policy describes prior authorization and binding in compliance with the listed statutes as updated by SB 249(2019). • 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: _____
Workers' compensation claims	OAR 836-053-0100 OAR 836-053-0105	Requires health benefit plans to provide coverage for claims for covered services denied or not yet adjudicated by the workers' compensation carrier.	Confirmed ☐
PRESCRIPTION DRUGS			
Prescription drugs	ORS 743A.062	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 Oregon Health Resources Commission determines the use is effective.	Confirmed ☐
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.	Confirm ☐
90 day supply of prescription	ORS 743A.063	A health benefit plan that provides coverage for a prescription drug benefit program must provide reimbursement for up to a 90-day supply of a prescription drug dispensed by a pharmacy.	Page: _____ Paragraph or Section: ☐
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 836-053-0008(1)(a); or the same number of prescription drugs in each category and class as the prescription drug coverage of the plan described in OAR 836-053-0008(1)(a).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 ☐

Category	Reference	Description of review standards requirements	Answer
Drug Formularies	OAR 836-053-1020(8) OAR 836-053-1020, 45 CFR 156.122	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. A plan's formulary must contain an exception process unless the product is using an open formulary. An insurer that uses a closed formulary must have a written procedure stating that FDA approved prescription drug products are covered only if they are listed in the formulary. The procedure must also describe how the insurer determines the content of the closed formulary and how the insurer determines the application of a medical exception. The procedure must describe how a provider may request inclusion of a new item in the closed formulary and must ensure that the insurer will issue a timely written response to a provider making such a request. Such procedures must include a process for an enrollee, the enrollee's designee, or the enrollee's prescribing physician (or other prescriber) to request an expedited review based on exigent circumstances. A health plan must make its coverage determination on an expedited review request based on exigent circumstances and notify the enrollee or the enrollee's designee and the prescribing physician (or other prescriber, as appropriate) of its coverage determination no later than 24 hours after it receives the request.	Confirmed ☐ N/A ☐
	Open formulary OAR 836-053-1020(2)	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.	Confirmed ☐ N/A ☐

Category	Reference	Description of review standards requirements	Answer
Drug Formularies	**Mandatory closed formulary** ORS 743B.250, OAR 836-053-1020(4), OAR 836-053-1030(11)	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. The insurer must also include a written procedure that describes the following: • 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 • An insurer will issue a timely written response to a provider making such a request.	Page: _____ Paragraph or Section: _____ N/A ☐
	Opioid withdrawal medication ORS 743B.425	In reimbursing the cost of medication prescribed for the purpose of treating opioid or opiate withdrawal, an insurer offering a health benefit plan as defined in ORS 743B.005 may not require prior authorization of payment during the first 30 days of treatment.	Confirmed ☐
Drug formularies, continued	**Step therapy** ORS 743B.602	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	Confirmed ☐ N/A ☐
	Synchronization plan ORS 743B.601	Requires health benefit plans to provide a means for insureds to synchronize prescriptions.	Confirmed ☐

PROVIDER REIMBURSEMENT			
Category	Reference	Description	Page and paragraph
Acupuncturist	ORS 743A.020	A policy that provides coverage for acupuncture services performed by a physician shall provide coverage for acupuncture services performed by a licensed acupuncturist. The coverage required may be made subject to provisions of the policy that apply to other benefits under the policy, including, but not limited to, provisions related to deductibles and coinsurance and shall be computed in the same manner whether performed by a physician or an acupuncturist.	Page: _____ Paragraph or Section: _____ N/A ☐

Category	Reference	Description	Page and paragraph
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: _____
Clinical social worker	ORS 743A.024*	Whenever any individual 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 ☐
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 ☐
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 ☐
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 ☐

Category	Reference	Description	Page and paragraph
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.	Page: _____ Paragraph or Section: _____ N/A ☐
Pharmacists	ORS 743A.051	Whenever the plan provides for payment or reimbursement for a service that is within the lawful scope of practice of a pharmacist, the insurer may provide payment or reimbursement for the service when the service is provided by a pharmacist	Page: _____ Paragraph or Section: _____
Physician assistant	ORS 743A.044	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: _____
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	Page: _____ Paragraph or Section: _____
Psychologist	ORS 743A.048	Coverage provides reimbursement for any service that is within the lawful scope of practice of a duly licensed psychologist, if the policy provided benefits when a physician performed the service.	Page: _____ Paragraph or Section: _____ N/A ☐

Category	Reference	Description	Page and paragraph or confirm
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 ☐
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 ☐

BENCHMARK PLANS			
Category	Reference	Description	Confirm
Marketplace	**Bronze, Silver and Gold Standard Plans** ORS 743B.130 OAR 836-053-0013	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 ☐
Base benchmark plan	OAR 836-053-0012	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. Standard plan must follow guidelines as provided in the referenced rule. **Note:** Additionally, standard plan benefits may not exceed the benchmark plan benefits***.***	Confirmed ☐

Category	Reference	Description	Page and paragraph
Base benchmark plan	**Standard plan naming convention:** OAR 836-053-0013(4)(a)	The plan name for standard plans must be in the exact naming convention below: "[Name of Issuer]Standard [Bronze/Silver] Plan" The name of insurer may be shortened to an easily identifiable acronym that is commonly used by the insurer in consumer facing publications. 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.	Page: _____ Paragraph or Section: _____ N/A ☐
	Copays and coinsurance OAR 836-053-0013(9)	Copays and coinsurance must comply with the following: • 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. • 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. • Coinsurance for emergency room coverage must be waived if a patient is admitted. Inpatient coinsurance applies if covered person is admitted.	Page: _____ Paragraph or Section: _____
	Deductibles OAR 836-053-0013(10)	Deductibles must comply with the following; • 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: _____

Category	Reference	Description	Page and paragraph or confirm
Base benchmark plan	**Dollar limits** OAR 836-053-0013(11)	Annual dollar limits and lifetime dollar limits must be converted to a non-dollar actuarial equivalent.	Confirmed ☐
	Prescription drugs OAR 836-053-0013(8)	Prescription drug coverage: • 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 ☐
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 ☐ N/A ☐
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 ☐
Waiting periods	ORS 743B.125, 45 CFR 147.116	Individual coverage waiting periods are prohibited.	Confirmed ☐
Catastrophic plans	ORS 743.826, 42 USC 18022(e)	If a carrier offers a catastrophic plan it must be offered on and off the Oregon Health Insurance Marketplace and only to an individual who: (1) Is under 30 years of age at the beginning of the plan year; or (2) Is exempt from any state or federal penalties imposed for failing to maintain minimal essential coverage during the plan year.	Page: _____ Paragraph or Section: _____