Department of Consumer and Business Services
Oregon Division of Financial Regulation - 5
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Standard Provisions for Group or Individual Event Based Policies for Hospital Confinement Indemnity and Health Indemnity Other than Hospital

This product standard checklist must be submitted with your filing, in compliance with OAR 836-010-0011(2). If this filing includes any expense-based benefits the filing will be disapproved.

The standards are summaries and review of the entire statute or rule will be necessary**.** Complete each item to confirm that diligent consideration has been given to each and is certified by the signature on the certificate of compliance form.

“Not applicable” can be used only if the item does not apply to the coverage being filed. Filings that do not include required information or policy provision will result in delays of the filing.

Insurer name: _____ **Date:** _____

TOI (type of insurance):

☐ **H14I Individual Hospital Indemnity**
☐ **H14G Group Hospital Indemnity**

An insurance contract that pays a fixed dollar amount without regard to the actual expenses incurred for each day the covered person is ***confined to the hospital*** as a result of injury, sickness, and/or medical condition. If other than hospital indemnity, use the TOI of H23I Individual Indemnity or H23G Group Indemnity for Other than Hospital.

Sub TOI:

☐ **H14I.000 Health-Hospital Indemnity**
☐ **H14G.000 Health-Hospital Indemnity**

TOI (Type of insurance)

☐ **H23I Individual Health-Indemnity Other than Hospital**
☐ **H23G Group Health-Indemnity Other than Hospital**

An insurance contract that pays a fixed dollar amount without regard to the actual expenses incurred as a result of injury, sickness, and/or medical condition. If hospital indemnity, use the TOI of H14I Individual Hospital Indemnity or H14G Group Hospital Indemnity.

Sub TOI:

☐ **H23I.000 Accident Only Indemnity**
☐ **H23I.001 Sickness Only Indemnity**
☐ **H23I.002 Accident/Sickness Indemnity**
☐ **H23I.003 Other Indemnity**

☐ **H23G.000 Accident Only Indemnity**
☐ **H23G.001 Sickness Only Indemnity**
☐ **H23G.002 Accident/Sickness Indemnity**
☐ **H23G.003 Other Indemnity**

GENERAL REQUIREMENTS (FOR ALL FILINGS)			
Category	Reference	Description of review standards requirements	Answer
Submission package requirements	**SERFF or Oregon Division of Financial Regulation website:** OAR 836-010-0011	http://dfr.oregon.gov/rates-forms/Pages/index.aspx These must be submitted for your filing to be accepted as complete: 1. Filing description or cover letter. 2. Third party filer's letter of authorization. 3. Certificate of compliance form signed and dated by authorized persons. 4. Readability certification. 5. Product standards for forms (this document). 6. Forms filed for approval. (If filing revised forms, include a ***highlighted/redline form version*** of the revised form to identify the modification, revision, or replacement language.) 7. Statement of Variability (see "Variability in forms" section).	Yes N/A ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
Filing description or cover letter	OAR 836-010-011(4), ORS 731.296	The filing description or cover letter includes the following: 1. Changes made to previously-approved forms or variations from other approved forms. 2. Summary of the differences between previously approved similar forms and the new forms. 3. The differences between in-network and out-of-network, if applicable. **Note:** If filing through SERFF, DFR recommends that the cover letter be included in a separate document under the Supporting Documentation tab rather than in the General Information tab. If the filing description under the General Information tab is used, post submission changes to this language are not allowed.	Yes N/A ☐ ☐ ☐ ☐ ☐ ☐
Purpose of filing	ORS 742.003(1), OAR 836-010-0011(3)	The following are submitted in this filing for review: 1. New policy and/or certificate. Includes related advertising material ORS 742.009, OAR 836-020-0200. 2. Changes to previously-approved forms include ***highlighted/redline version***. 3. Endorsements and/or amendments modify the policy by changing the coverage afforded under the previously approved policy. 4. Riders provide for additional or greater benefits than those in the base policy and no part of the rider revises the policy to reduce benefits or provide less favorable terms than in the policy. Riders must be applicable to the TOI filed under this standard 5. If the base policy was approved over 5 years, please submit a complete filing that includes all amendment and/or riders. The revised filing needs to include the highlighted/redline version.	Yes N/A ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

Category	Reference	Description of review standards requirements	Answer
Clear policy language	ORS 742.005(2)	The policy provisions and benefit descriptions are clear and not ambiguous, abstruse, unintelligible, uncertain, or likely to mislead.	Yes ☐ N/A ☐
	ORS 743.106(1)(c)(d)	The style, arrangement, and overall appearance of the policy may not give undue prominence to any portion of the text. The policy contains a table of contents or an index of the principal sections of the policy, if the policy has more than 3,000 words.	Yes ☐ N/A ☐
	ORS 743.104(2)	A non-English language policy will be deemed to comply with ORS 743.106 if the insurer certifies that the policy is translated from an English language policy that complies with ORS 743.106.	Yes ☐ N/A ☐
	ORS 743.106(1)(b)	The font shall be uniform and not less than 12-point type	Confirmed ☐
Cover page	**Disclosure** ORS 742.005, OAR 836-010-0011, OAR 836-020-0305, 45 CFR 148.220(b)(iv**)**	1. The full corporate name of the insuring company appears prominently on the first page of the policy. 2. A marketing name or insurer's logo, if used on the policy, must not mislead as to the identity of the insuring company and may not be bracketed. 3. The insuring company address, consisting of at least a city and state, appears on the first page of the policy. 4. The signature of at least one company officer appears on the first page of the policy. 5. A form-identification number appears in the lower left-hand corner of all forms. 6. All pages are numbered. 7. The policy contains a brief caption that appears prominently on the cover page and describes the type of coverage. 8. The policy includes a right-to-examine provision that appears on the cover page. 9. A notice is displayed prominently in the application materials in at least 14 point type that has the following language: **"THIS IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. LACK OF MAJOR MEDICAL COVERAGE (OR OTHER MINIMUM ESSENTIAL COVERAGE) MAY RESULT IN AN ADDITIONAL PAYMENT WITH YOUR TAXES."**	Yes ☐ N/A ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ Confirmed ☐ Confirmed ☐ Confirmed ☐

Category	Reference	Description of review standards requirements	Answer
Cover page	**Medicare Supplement** OAR 836-052-0160 (5)(a)(b), Exhibit 1, Appendix C	10**.** The first page of the outline of coverage delivered to insureds under the policy, or if no outline of coverage is delivered, to the first page of the policy or certificate delivered to insureds. The notice shall be in no less than 12 point type and shall contain the following language: **"THIS (POLICY OR CERTIFICATE) IS NOT A MEDICARE SUPPLEMENT (POLICY OR CONTRACT). If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from the company."**	Yes ☐ No ☐
	Outline of Coverage OAR 836-020-305 Exhibit 2, Form B	Summarizes important features of the policy, provisions that exclude, eliminate, restrict, limit, delay or in any way operate to qualify payment of benefits.	Yes ☐ No ☐
Form numbers	OAR 836-010-0011	The policy and certificate are filed under one form number if both are required to complete the contract, and the form provides core coverage with all basic requirements. **Note:** if the policy and certificate are free-standing documents, they must each have their own unique form number. Optional benefits to the policyholder are riders or endorsements with separate form numbers.	Yes ☐ N/A ☐
Variability in forms	ORS 742.003, ORS 742.005(2)	Variable material in forms will only be permitted if it is clearly identified by brackets along with an explanation of when each would be used. • Variable text includes all optional text, changes in language, and choices in terms or provisions. • Variable numbers are limited to numerical values showing all ranges (minimum to maximum benefit amounts). • Explanation must be clear and complete. • The filing includes a certification that any change outside the approved ranges will be submitted for prior approval • Variability in forms may be described either through embedded Drafter's Notes or a separate Statement of Variability form. In general, Drafter's Notes are preferred. **Note:** detailed variability instructions can be found at: http://dfr.oregon.gov/rates-forms/health/Pages/health.aspx	Yes ☐ N/A ☐

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

(*Skip to Requirements for Individual Rates if filing only a rate change.*)

POLICY PROVISIONS			
Category	Reference	Description of review standards requirements	Page & paragraph
Hospital Indemnity	OAR 836-020-0775 (10)(a),(b)	Means benefits not related to expenses incurred; and "Hospital indemnity benefits" does not include reimbursement-type benefits even if they are designed or administered to give the insured the right to elect indemnity-type benefits at the time of claim.	Page: Paragraph or Section:
	OAR 836-020-0775 (11)(d)(A)	Independent, non-coordinated, hospital-only indemnity insurance or other fixed indemnity insurance;	
Limited Benefit coverage	ORS 731.114 (2), ORS 743B.005 (16)(b)(G)	Independent, non-coordinated, hospital-only indemnity insurance or other fixed indemnity insurance.	
Individual health insurance policy	ORS 743.405(1) through (8)	An individual health insurance policy **must** meet the following requirements: 1. Include a statement of money and considerations due; 2. Define the start and stop date; 3. Define who is covered under the plan; 4. May not be used to separate an individual from a group product under which they are eligible for coverage; 5. The policy may not give undue prominence to any provision, the style must be consistent and uniform throughout, and must be in 12 point font; 6. Exclusions and limitations must be clearly stated; 7. Each policy forms must be identified by a unique form number in the lower left portion of each page; 8. No portion of the insurers' internal corporate regulations may be made part of the policy.	Page: Paragraph or Section

Category	Reference	Description of review standards requirements	Page & paragraph
Individual health insurance policy EXCEPTED BENEFIT REQUIREMENTS	ORS 743.405(1) through (8)	An individual health insurance policy **must** meet the following requirements: 9. Include a statement of money and considerations due; 10. Define the start and stop date; 11. Define who is covered under the plan; 12. May not be used to separate an individual from a group product under which they are eligible for coverage; 13. The policy may not give undue prominence to any provision, the style must be consistent and uniform throughout, and must be in 12 point font; 14. Exclusions and limitations must be clearly stated; 15. Each policy forms must be identified by a unique form number in the lower left portion of each page; 16. No portion of the insurers' internal corporate regulations may be made part of the policy.	Page: Paragraph or Section
EXCEPTED BENEFIT REQUIREMENTS	**Excepted benefits (Individual)** 45 CFR 148.220(b)(4),	**(4)** Hospital indemnity or other fixed indemnity insurance only if - **(i)** The benefits are provided only to individuals who attest, in their fixed indemnity insurance application, that they have other health coverage that is minimum essential coverage within the meaning of section 5000A(f) of the Internal Revenue Code, or that they are treated as having minimum essential coverage due to their status as a bona fide resident of any possession of the United States pursuant to Code section 5000A(f)(4)(B). **(ii)** There is no coordination between the provision of benefits and an exclusion of benefits under any other health coverage. **(iii)** The benefits are paid in a fixed dollar amount per period of hospitalization or illness and/or per service (for example, $100/day or $50/visit) regardless of the amount of expenses incurred and without regard to the amount of benefits provided with respect to the event or service under any other health coverage. **(iv)** A notice is displayed prominently in the application materials in at least 14 point type that has the following language: "THIS IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. LACK OF MAJOR MEDICAL COVERAGE (OR OTHER MINIMUM ESSENTIAL COVERAGE) MAY RESULT IN AN ADDITIONAL PAYMENT WITH YOUR TAXES."	Page: Paragraph or Section

Category	Reference	Description of review standards requirements	Page & paragraph
EXCEPTED BENEFIT REQUIREMENTS	**Excepted benefits (Individual)** 45 CFR 148.220(b)(4),	**(v)** The requirement of paragraph (b)(4)(iv) of this section applies to all hospital or other fixed indemnity insurance policy years beginning on or after January 1, 2015, and the requirement of paragraph (b)(4)(i) of this section applies to hospital or other fixed indemnity insurance policies issued on or after January 1, 2015, and to hospital or other fixed indemnity policies issued before that date, upon their first renewal occurring on or after October 1, 2016.	Page: Paragraph or Section
Group health insurance policy	**Summary of essential features of coverage** ORS 743.406(2)	Policy shall contain a provision that the insurer will furnish to the policyholder for delivery to each employee or member of the insured group a statement in summary form of the essential features of the insurance coverage of the employee or member, to whom the insurance benefits are payable.	Page: Paragraph or Section
	Applicable rights and conditions ORS 743B.340, ORS 743B.341 and ORS 743B.343 to ORS 743B.347	Policy shall provide the rights and conditions relating to premium contributions, continuation of benefits after termination and availability of continued coverage under group policy for surviving, divorced or separated spouse 55 or older as prescribed.	Page: Paragraph or Section
EXCEPTED BENEFITS REQUIREMENTS (continued next pg)	**Federal FAQ 11, Q7 (Group only)**	Q7: What are the circumstances under which fixed indemnity coverage constitutes excepted benefits? The Departments' regulations provide that a hospital indemnity or other fixed indemnity insurance policy under a group health plan provides excepted benefits only if: •The benefits are provided under a separate policy, certificate, or contract of insurance; •There is no coordination between the provision of the benefits and an exclusion of benefits under any group health plan maintained by the same plan sponsor; and •The benefits are paid with respect to an event without regard to whether benefits are provided with respect to the event under any group health plan maintained by the same plan sponsor.	Page: Paragraph or Section

Category	Reference	Description of review standards requirements	Page & paragraph
EXCEPTED BENEFITS REQUIREMENTS Federal interpretation	**Federal FAQ 11, Q7 (Group only)**	•There is no coordination between the provision of the benefits and an exclusion of benefits under any group health plan maintained by the same plan sponsor; and •The benefits are paid with respect to an event without regard to whether benefits are provided with respect to the event under any group health plan maintained by the same plan sponsor. The regulations further provide that to be hospital indemnity or other fixed indemnity insurance, the insurance must pay a fixed dollar amount per day (or per other period) of hospitalization or illness (for example, $100/day) regardless of the amount of expenses incurred. Various situations have come to the attention of the Departments where a health insurance policy is advertised as fixed indemnity coverage, but then covers doctors' visits at $50 per visit, hospitalization at $100 per day, various surgical procedures at different dollar rates per procedure, and/or prescription drugs at $15 per prescription. In such circumstances, for doctors' visits, surgery, and prescription drugs, payment is made not on a per-period basis, but instead is based on the type of procedure or item, such as the surgery or doctor visit actually performed or the prescribed drug, and the amount of payment varies widely based on the type of surgery or the cost of the drug. Because office visits and surgery are not paid based on "a fixed dollar amount per day (or per other period)," a policy such as this is not hospital indemnity or other fixed indemnity insurance, and is therefore not excepted benefits. When a policy pays on a per-service basis as opposed to on a per-period basis, it is in practice a form of health coverage instead of an income replacement policy. Accordingly, it does not meet the conditions for excepted benefits. The Departments plan to work with the States to ensure that health insurance issuers comply with the relevant requirements for different types of insurance policies and provide consumers with the protections of the Affordable Care Act.	Page: Paragraph or Section

Category	Reference	Description of review standards requirements	Page & paragraph
Group health insurance policy, continued	**Adding employees/members** ORS 743.406(3)	A provision that to the group originally insured may be added from time to time eligible new employees or members or dependents, as the case may be, in accordance with the terms of the policy.	Page: Paragraph or Section
	Excepted benefits for Groups 45 CFR 146.145(b)(4)	**(i)***Excepted benefits that are not coordinated.* hospital indemnity or other fixed indemnity insurance is excepted only if it meets each of the conditions specified in paragraph (b)(4)(ii) of this section. To be hospital indemnity or other fixed indemnity insurance, the insurance **must pay a fixed dollar amount per day (or per other period)** of hospitalization or illness (for example, $100/day) regardless of the amount of expenses incurred. **(ii)***Conditions.* Benefits are described in paragraph (b)(4)(i) of this section only if - **(A)** The benefits are provided under a separate policy, certificate, or contract of insurance; **(B)** There is no coordination between the provision of the benefits and an exclusion of benefits under any group health plan maintained by the same plan sponsor; and **(C)** The benefits are paid with respect to an event without regard to whether benefits are provided with respect to the event under any group health plan maintained by the same plan sponsor. **(iii)***Example.* The rules of this paragraph (b)(4) are illustrated by the following example: **EXAMPLE.** **(i)***Facts.* An employer sponsors a group health plan that provides coverage through an insurance policy. The policy provides benefits only for hospital stays at a fixed percentage of hospital expenses up to a maximum of $100 a day. **(ii)***Conclusion.* In this *Example,* even though the benefits under the policy satisfy the conditions in paragraph (b)(4)(ii) of this section, because the policy pays a percentage of expenses incurred rather than a fixed dollar amount, the benefits under the policy are not excepted benefits under this paragraph (b)(4). This is the result even if, in practice, the policy pays the maximum of $100 for every day of hospitalization.	Page: Paragraph or Section

Category	Reference	Description of review standards requirements	Page & paragraph
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 NA ☐
Beneficiaries	ORS 743.444	Policy states that unless the insured makes an irrevocable designation of beneficiary, the right to change beneficiary is reserved to the insured and the consent of the beneficiary shall not be requisite to surrender or assignment of this policy.	Page: Paragraph or Section
Cancellation and nonrenewal	ORS 743.495, ORS 743.498	A non-cancelable or guaranteed renewable policy includes the statement required by ORS 743.498 or similar language explaining the guaranteed or cancelable periods.	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, providing that if claim forms are required and are not furnished within 15 days after the claimant gives notice of claim, the claimant shall be deemed to have complied with the requirement of the policy.	Page: Paragraph or Section
Claim notice	ORS 743.423(1)	The "notice of claim" statement in ORS 743.423(1), or a similar statement, is included in the policy, explaining that written notice of claim is given to the insurer within 20 days after occurrence or commencement of any loss covered by the policy or as soon thereafter as is reasonably possible.	Page: Paragraph or Section
Claim payment	ORS 743.432 ORS 743.435	A "time payment of claims" statement similar to that in ORS 743.432 is included in the policy, stating that indemnities payable will be paid immediately upon receipt of due written proof of loss or stating the intervals of periodic payment of benefits.	Page: Paragraph or Section
		Policy states that benefits paid for loss of life are payable in accordance with the beneficiary designation. If no such designation or provision is in effect, such payments shall be payable to the estate of the insured.	Page: Paragraph or Section

Category	Reference	Description of review standards requirements	Confirm compliance
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 ☐
Discrimination	**Unfair Discrimination Identified** OAR 836-080-0050, OAR 836-080-0055	Distinctions based on sex, sexual orientation, or marital status made in the following matters constitute unfair discrimination: • The availability of a particular insurance policy. • The availability of a particular amount of insurance or set of coverage delimiting factors. The availability of a particular policy coverage or type of benefit, except for those relating to physical characteristics unique to one sex.	Confirmed ☐
	ORS 746.015	No person shall make or permit any unfair discrimination between individuals of the same class and equal expectation of life, or between risks of essentially the same degree of hazard.	Confirmed ☐
	Age 65 ORS 746.015(3)	This contract complies with ORS 746.015(3) by not discriminating against a person who attains or exceeds age 65, unless such discrimination is based on clear and sound actuarial principals as well as anticipated experience.	Confirmed ☐
	Domestic violence ORS 746.015(4)	This contract complies with ORS 746.015(4) by not cancelling, refusing to issue or renew this policy on the basis of the fact that an insured or prospective insured is or has been a victim of domestic violence.	Confirmed ☐
	Physical disability ORS 746.015(2)	This contract complies with ORS 746.015(2) by not discriminating in its underwriting standards and or rates solely on an individual's physical disability.	Confirmed ☐
	Diethylstilbestrol use by mother ORS 743A.088	No policy of health insurance may be denied or canceled by the insurer solely because the mother of the insured used drugs containing diethylstilbestrol prior to the insured's birth.	Confirmed ☐
	Domestic partners (The Oregon Family Fairness Act) ORS 106.300 to ORS 106.340, Bulletin 2008-2	A domestic partnership is defined in ORS 106.310 as "a civil contract entered into in person between two individuals of the same sex who are at least 18 years of age, who are otherwise capable and at least one of whom is a resident of Oregon." **Any time that coverage is extended to a spouse it must also extend to a domestic partner, requirements beyond this are not allowed for same sex domestic partners.**	Confirmed ☐
	Gender Dysphoria 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.	Confirmed ☐

Category	Reference	Description of review standards requirements	Page & paragraph or confirm
Discrimination (continued)	**Genetic information** 45 CFR §146.122, ORS 746.135	Issuers may not discriminate on the basis of genetic information.	Confirmed ☐
	Medicaid ORS 743B.470(2) **Children out of wedlock** ORS 743B.470 (6)	Eligibility for benefits is not determined based on eligibility for Medicaid. Policy covers children not residing with the parent, not claimed as dependents on parents' federal tax return, born out of wedlock, or residing in the insurer's service area.	Confirmed ☐
	Same-sex marriages performed in other states OAR 836-010-0150	Oregon recognizes the marriages of same-sex couples validly performed in other jurisdictions to the same extent that they recognize other marriages validly performed in other jurisdictions	Confirmed ☐
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:
Fraud statements	Bulletin 2010-03 ORS 742.013	Fraud or misstatement warnings that mention criminal or civil penalties must avoid definite statements of the criminal nature of an act, guilt, or possible penalties. A warning that specifies that knowingly providing false information "may be" a crime, which "may be" grounds for criminal or civil penalties is appropriate.	Page: Paragraph or Section:
Grace period	ORS 743.417	Provision states that a minimum 10-day grace period is granted for the payment of each premium falling due after the first premium, during which the policy shall continue in force.	Page: Paragraph or Section:
	ORS 743B.320	743B.320 Minimum grace period; notice upon termination of policy; effect of failure to notify. (1) A group health insurance policy shall contain a provision allowing a minimum grace period of 10 days after the premium due date for payment of premium.	Page: Paragraph or Section:
	ORS 743B.323	743B.323 Separate notice to policyholder required before cancellation of individual or group health insurance policy for nonpayment of premium. Before a health insurer selling an individual policy or group health benefit plan, as defined in ORS 743B.005, may cancel a policy for nonpayment of premium, the insurer must mail a separate notice to the policyholder at least 10 days prior to the end of the grace period informing the policyholder that the premium was not received and that the policy will be terminated as of the premium due date if the premium is not received by the end of the applicable grace period required by ORS 743.417 and 743B.320. The notice shall be in writing and mailed by first class mail to the last-known address of the policyholder. [Formerly 743.565]	Page: Paragraph or Section:

Category	Reference	Description of review standards requirements	Page & paragraph or Confirm
Incontestability	ORS 743.414(3),(4)	The “incontestable” statement in ORS 743.414(3) and (4) or a similar statement is included that states after two years from the date of issue of this policy, no misstatements except fraudulent misstatements made by the applicant shall be used to void the policy or to deny a claim, and losses after two years are covered.	Page: Paragraph or Section:
Inducements not specified in the 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.	Confirmed ☐
Legal action	ORS 743.441	Provision states that no action at law or in equity is brought to recover on this policy prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the policy. No action shall be brought after the expiration of three years after the time written proof of loss is required.	Page: Paragraph or Section:
Physical examination/ autopsy	ORS 743.438	The “physical examinations and autopsy” statement in ORS 743.438 or a similar statement is included in the policy, explaining that the insurer at its own expense shall have the right and opportunity to examine the insured when and as often as it may reasonably require while a claim is pending.	Page: Paragraph or Section:
Proof of loss	ORS 743.429 OAR 836-080-0230 and -0235	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.	Page: Paragraph or Section:
		If the policy includes claim procedures, the procedures and timelines comply with fair claim practice requirements.	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, which is not specified in the policy.	Confirmed ☐
Reinstatement	ORS 743.420	A provision states that if the renewal premium has not been paid within the time granted but an insurer or authorized agent subsequently accepts a premium the policy shall be reinstated. The only exception is an application for reinstatement required to be submitted by the enrollee and accepted by the insurer.	Page: Paragraph or Section:
Representations not warranties	ORS 743.406(1) (group)	A provision that, in the absence of fraud, all statements made by applicants, the policyholder or an insured person shall be deemed representations and not warranties. No statement made for the purpose of effecting insurance shall avoid the insurance or reduce benefits unless contained in a written instrument signed by the policyholder or the insured person, a copy of which has been furnished to the policyholder or to the person or the beneficiary of the person.	Page: Paragraph or Section:

Category	Reference	Description of review standards requirements	Page & paragraph
Time limit on certain defenses	ORS 743.414(1)	A provision states that after two years from the date of issue of the policy no misstatements except fraudulent misstatements made by the applicant shall be used to void the policy or to deny a claim.	Page: Paragraph or Section:
	ORS 743.414(2)	The policy provision does not affect any legal requirement for avoidance of a policy or denial of a claim during the first two-year period or limit the application of ORS **743.450 to 743.462** in the event of misstatement with respect to age or occupation or other insurance.	Page: Paragraph or Section:
BENEFIT REIMBURSEMENT			
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:
Prescription drugs	ORS 743A.060 ORS 743A.062	No Insurance policy or contract providing coverage of a prescription drug coverage shall exclude coverage of a drug because the drug is not FDA approved for a prescribed medical condition if the Oregon Health Resources Commission determines the use is effective. “Peer-reviewed medical literature” does not include internal publications of pharmaceutical manufacturers	Page: Paragraph or Section:
State hospital	ORS 743A.010	Policy pays benefits for covered services when provided by any hospital owned or operated by the State of Oregon or any state approved community mental health and developmental disabilities program. No policy of health insurance shall exclude from payment or reimbursement losses incurred by an insured for any covered service because the service was rendered at any hospital owned or operated by the State of Oregon or any state approved community mental health program or community developmental disabilities program	Page: Paragraph or Section:
Pelvic and Pap smear examinations	ORS 743A.104	All policies providing health insurance, shall include coverage for pelvic examinations and Pap smear examinations.	Page: Paragraph or Section:
Nonprescription elemental enteral formula for the treatment of severe intestinal malabsorption	ORS 743A.070	Any policy providing health insurance, shall include coverage for a nonprescription elemental enteral formula for home use, if the formula is medically necessary for the treatment of severe intestinal malabsorption and a physician has issued a written order for the formula and the formula comprises the sole source, or an essential source, of nutrition	Page: Paragraph or Section:

REQUIREMENTS FOR RATE FILINGS: INDIVIDUAL POLICIES ONLY *Information requested under this section is determined to be necessary to evaluate the filing for compliance.*			
Category	Reference	Description of review standards requirements	Page & paragraph
Filing request	ORS 743.018	The following review is requested: 1. New rate filing. 2. Rate change. 3. Informational.	Requested ☐ ☐ ☐
Classes	ORS 742.005(2), ORS 743.018	If the insurer uses class for the purpose of rating, the policy includes a definition of class that is consistent with the actuarial basis.	Yes ☐
Combined classes	ORS 742.041	This filing includes classes of combined life and health insurance. (*No other classes are combined in this filing in which the liability of the insurer for unearned premiums or the reserve for unpaid, deferred, or undetermined-loss claims is estimated in a different manner*.)	Yes ☐
	Loss ratio	**Rate changes.** Successive generic policy forms of similar benefits covering generations of policyholders must be combined in the calculation of premium rates and loss ratios.	Yes ☐
Premium changes	ORS 742.005(6), ORS 743.018	Premium changes are subject to prior approval and should not be filed more than once in a 12-month period. Benefits provided in the contract should be reasonable in relation to the premium charged.	Yes ☐
Ratemaking	ORS 743.018, OAR 836-010-0011	Appendix A (Form 440-2462) is included and all columns completed showing support of the rate change requested; it includes actual and projected experience and overall loss ratio from policy inception for Oregon and the company's national experience. (See website: http://dfr.oregon.gov/rates-forms/Documents/2462.pdf)	Yes ☐
		A complete actuarial memorandum, signed by an accredited actuary, is included containing a description of all policy benefits and the actuarial assumptions used to develop each of the benefits. (*Include a description of the risk and the assumptions used in developing the cost.*)	Yes ☐
		The expected experience of the new rate or existing rate for the projected calculating period over which the actuary expects the premium rates to remain adequate is based on estimated future experience without expected rate increases.	Yes ☐
		The source of the data; information about new or experimental benefits; and explanation of the reliability of projections, abrupt changes in the experience, and substantial differences between actual and expected experience are included.	Yes ☐
		The premium structure, as defined by the classification of insureds in the policy, is not changed at the time of rate increase (e.g., changes from issue-age to attained-age basis).	Yes ☐

Category	Reference	Description of review standards requirements	Page & paragraph
Ratemaking, continued	OAR 836-010-0011	A statement that the grouping of policy forms has not changed or an explanation of the changes is included. Experience of forms must be grouped according to similar types of benefits, claims experience, reserves, margins for contingencies, expenses and profit, renewability, underwriting, and equity between policyholders.	Yes ☐
	ORS 733.030	Filing identifies how reserving assumptions (including specific company experience) take into account any expected adverse mortality and lapses that are reflected in the pricing.	Yes ☐
Underwriting	OAR 836-010-0011	Mark the type of health underwriting filed for the forms included in this rate request: 1. Full underwriting. 2. Simplified underwriting. 3. No underwriting.	Mark one ☐ ☐ ☐
	ORS 746.600(1)(a)(D) Adverse underwriting	No practices or procedures imply or provide for "adverse underwriting" by offering individuals insurance at higher-than-standard rates.	Confirm ☐

CMS Jim Mayhew input from 12/7/18

Coverage, to be a fixed indemnity excepted benefit, can pay on either a per-period or per-service basis, as long as it pays "regardless of the amount of expenses incurred". Given that the amount paid per-service under this coverage is derived from the amount Medicare would pay for that service, and the amount Medicare would pay for that service is based on the amount of expenses incurred, … this coverage does not qualify as a fixed indemnity excepted benefit.

*We have always interpreted the phrase 'regardless of the amount of expenses incurred' **as meaning that the amount the policy pays cannot be a function of how much the item or procedure** costs, for example, how much another payer (such as Medicare) would pay for that item or service. In addition, **regulators should use reasonable judgment to decide if a policy constitutes fixed indemnity coverage.** To establish a detailed payment schedule and set the level of payment based on a percentage of Medicare makes the coverage essentially indistinguishable from major medical coverage, which is contrary to the intent of the regulations on fixed indemnity coverage.*