Department of Consumer & Business Services
Oregon Division of Financial Regulation - 5
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Standard Provisions for Student Health Benefit Plans (ORS 743.551, 45 CFR §147.145)

This product standards checklist is for student health benefit plans, which are defined federally as a type of individual health insurance coverage between an institution of higher education and a health insurance issuer that is provided to students who are enrolled in that institution of higher education and their dependents (42 U.S.C. 18118(c)). In Oregon, student health benefit plans are considered group coverage because the institution of higher education is the policyholder.

This list includes relevant statutes, rules, bulletins, and other documented positions to enforce ORS 731.016. The standards are summaries and review of the entire statute or rule may be necessary. Complete each item to confirm that diligent consideration has been given to each and is certified by the signature on the certificate of compliance form. “Not applicable” can be used only if the item does not apply to the coverage being filed.

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

TOI (type of insurance): ☐ H16G Group Health - Major Medical

Sub TOI: ☐ H16G.001C Any Size Group - Other

Type of coverage: ☐ Student Health (as defined above) — Department of Human Health and Human Services Under the Public Health Service Act (PHSA) and the Affordable Care Act (ACA) (45 CFR Parts 144 and 147)

Note: If filing Blanket Health and/or Student Health Blanket, complete product standard Form 440-2446 instead**.**

*** I*ndicates standard provision is not required for Health Care Service Contractors per ORS 750.055***

GENERAL REQUIREMENTS (FOR ALL FILINGS)			
Category	Reference	Description of review standards requirements	Answer
Submission package requirements	OAR 836-010-0011	Required forms are located on SERFF or on our website: http://dfr.oregon.gov/rates-forms/health/Pages/health.aspx These must be submitted with your filing to be accepted as complete: 1. NAIC transmittal form (paper filings only). 2. Filing description or cover letter. 3. Third party filer's letter of authorization. 4. Certificate of compliance form signed and dated by authorized person. 5. Readability certification. 6. Product standards for forms (this document).These are required and must be submitted with your filing, in compliance with OAR 836-010-0011(2). 7. Forms filed for approval. (If filing revised forms, include a ***highlighted*** copy of the revised form to identify the modification, revision, or replacement language.) 8. For mailed filings, two self-addressed stamped envelopes, one in which the Division of Financial Regulation can return approved forms. 9. If submitting your filings electronically, bookmark the provision(s) in the form(s) that satisfy the requirement and identify the page/paragraph on this form. 10. Statement of Variability (see "Variability in forms" section).	Yes N/A ☐
	OAR 836-010-0011(4) Filing description or cover letter	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, if applicable.	Yes N/A ☐ ☐ ☐ ☐ ☐ ☐
Review requested	ORS 742.003(1), OAR 836-010-0011(3), ORS 743.766	The following are submitted in this filing for review: 1. New policy. 2. Amendment of an approved form. 3. Endorsements or riders.	Yes N/A ☐ ☐ ☐ ☐ ☐ ☐

APPLICABILITY			
Category	Reference	Description of review standards requirements	Answer
Application	45 CFR §147.110, 45 CFR §146.121	No application with medical questions, except for tobacco use and age, is used to enlist new enrollees.	Yes N/A ☐ ☐
	Form 440-2442H	If applications or enrollment forms are included in the filing, please also submit Form 440-2442H *Standards for Health Applications*.	Yes N/A ☐ ☐
Assumption certificates	Form 440-3637	File assumption certificates under Form 440-3637 *Changes to Business Operations that Require a Filing*.	

Category	Reference	Description of review standards requirements	Answer
Health Care Service Contractors (HCSC)	ORS 750.055	Statute references followed by an asterisk (*), may be marked “N/A” in the location column. These standards do not apply to HCSCs per ORS 750.055.	
Modification and discontinuance	45 CFR §147.106, 45 CFR §148.122, OAR 836-053-0001	Submit Form 440-2896 *Transmittal and Requirements for Modification and Discontinuance of Health Benefit Plans* when making a uniform modification or discontinuing a plan.	Yes ☐ N/A ☐
Non-health benefit plans	ORS 743.730(18)(b)	Health benefit plan does not include coverages specifically listed in ORS 743.730(18)(b). (See Form 440-3172A, B, or C for filing those coverages.)	Confirmed ☐
Student health insurance coverage	45 CFR §147.145(a)	Student health insurance coverage is a type of individual health insurance coverage that is provided pursuant to a written agreement between an institution of higher education (as defined in the Higher Education Act of 1965) and a health insurance issuer, and provided to students enrolled in that institution of higher education and their dependents, that meets the following conditions: 1. Does not make health insurance coverage available other than in connection with enrollment as a student (or as a dependent of a student) in the institution of higher education. 2. Does not condition eligibility for the health insurance coverage on any health status-related factor (as defined in §146.121(a) of this subchapter) relating to a student (or a dependent of a student). 3. Meets any additional requirement that may be imposed under State law.	Confirmed ☐
	45 CFR §147.145(b)(ii)	Student health coverage is exempt from guaranteed availability requirements. A health insurance issuer that offers student health insurance coverage is not required to accept individuals who are not students or dependents of students in such coverage, and is not required to establish open enrollment periods or coverage effective dates that are based on a calendar policy year or to offer policies on a calendar year basis.	Confirmed ☐
	45 CFR §147.145(b)(iii)	Student health coverage is exempt for guaranteed renewability requirements. A health insurance issuer that offers student health insurance coverage is not required to renew or continue in force coverage for individuals who are no longer students or dependents of students.	Confirmed ☐

GENERAL FORM REQUIREMENTS			
Category	Reference	Description of review standards requirements	Answer
Clarity and readability	ORS 742.005(2) Clear and understandable	Forms are clear and understandable in their presentation of premiums, labels, description of contents, title, headings, backing, and other indications (including restrictions) in the provisions. The information is clear and understandable to the consumer and is not ambiguous, abstruse, unintelligible, uncertain, or likely to mislead.	Confirmed ☐
Cover page	National standards, ORS 742.005, OAR 836-010-0011, ORS 743.106(1)(d)	1. The full corporate name of the insuring company appears prominently on the first page of the policy. 2. A marketing name or insurer's logo, if used on the policy, must not mislead as to the identity of the insuring company. 3. The insuring company address, consisting of at least a city and state, appears on the first page of the policy. 4. The signature of at least one company officer appears on the first page of the policy. 5. A form-identification number appears in the lower left-hand corner of the forms. The form number is adequate to distinguish the form from all others used by the insurer. 6. The policy contains a brief caption that appears prominently on the cover page and describes the type of coverage.	Yes N/A ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
Form numbers	OAR 836-010-0011	The policy and certificate are filed under one form number if both are required to complete the contract, and the form provides core coverage with all basic requirements. 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.	Confirmed ☐
Table of contents	ORS 743.103, ORS 743.106(1)(d)	Policy contains a table of contents or index of the principal sections if longer than 3 pages or over 3,000 words.	Yes N/A ☐ ☐
Variability in forms	ORS 742.003, ORS 742.005(2) Variable text	All variable text is indicated by brackets showing language as either in or out of the contract; explains why the language is in, out, or variable; and provides a list of all available options. The specific conditions and circumstances under which each variable item may apply need to be explained in detail. For example: [123 Main, Anytown, ST] - Bracketed if address changes in the future [ABC Benefit] - Bracketed because may be included or excluded depending on policyholder's option	Yes N/A ☐ ☐

Category	Reference	Description of review standards requirements	Answer
Variability in forms, continued	ORS 742.003, ORS 742.005(2) Variable numbers	Variable data is indicated by brackets and is limited to numerical values showing ranges (minimum to maximum benefit amounts) and all reasonable and realistic ranges are identified for each item. For example: **Dollar ranges** - $[10 to 100] **Percentages** - [70 to 100]% **Time frames** - [30-180] days *If the full numerical range is encompassed within the brackets (as shown above), the explanations do not need to be listed on the SOV or through drafter's notes.*	Yes ☐ N/A ☐
	ORS 742.003, ORS 742.005(2) Ways to explain variability	**The following are acceptable ways to explain variability in forms:** 1. <u>DRAFTER'S NOTES:</u> Drafter's notes are embedded into the form and provide full explanation for all variable text and data. Drafter's notes should be highlighted or shaded in the embedded form and placed either directly before or after the variable text. 2. <u>STATEMENT OF VARIABILITY (SOV):</u> An SOV requires a unique form number on the lower left hand corner and submitted under the Form Schedule tab. The SOV must follow the bracketed sections in sequential order of the forms and provide detailed explanation of variability.	Yes ☐ N/A ☐
	ORS 742.003, ORS 742.005(2) Vague explanations not allowed	Vague and non-descript explanations, such as "to allow for future changes", is unacceptable and will not be allowed. Our responsibility is to review and approve all language and options; therefore, all ranges and/or options must be disclosed.	Yes ☐ N/A ☐
	ORS 742.003, ORS 742.005(2) Certification included	The filing also should include a certification that any change or modification to a variable item outside the approved ranges is submitted for prior approval of the change or modification. This certification may be included in the cover letter, filing description, or anywhere else in the filing as appropriate.	Page: Paragraph or Section: N/A ☐
POLICY PROVISIONS			
Category	Reference	Description of review standards requirements	Answer
Acupuncturist	ORS 743A.020	A policy that provides coverage for acupuncture services performed by a physician shall provide coverage for acupuncture services performed by an acupuncturist licensed under ORS 677.757 to 677.770.	Page: Paragraph or Section: N/A ☐

Category	Reference	Description of review standards requirements	Answer
Adding new members or dependents	ORS 743.528(3)	A provision that to the group originally insured may be added from time to time eligible new members or dependents, as the case may be, in accordance with the terms of the policy.	Page: Paragraph or Section:
Allowable charges	ORS 743.878(1)(b)*	A written methodology of how allowable expenses are determined.	Page: Paragraph or Section:
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: N/A ☐
Annual and lifetime dollar limits prohibited on EHBs	ORS 743.754(10), 45 CFR §147.126, 45 CFR §147.145(b)(2)(iii)	A health benefit plan may not impose annual or lifetime limits on the dollar amount of essential health benefits (EHBs).	Confirmed ☐
Arbitration	ORS 36.600 to 36.740	If the policy provides for arbitration if claim settlement cannot be reached, the parties may elect arbitration by mutual agreement at the time of the dispute after the claimant has exhausted all internal appeals and mutually-agreed arbitration can be binding. One party may initiate arbitration proceedings; however, if there is no mutual agreement the resulting arbitration is binding only on the party who demanded arbitration. Arbitration proceedings take place under the laws of Oregon and are held in the insured's county or another county in the state if agreed upon.	Page: Paragraph or Section: N/A ☐
Bilateral cochlear implants	ORS 743A.140	Whenever any policy of health insurance provides for reimbursement of a cochlear implant, the insured under the policy is entitled to coverage of bilateral cochlear implants.	Page: Paragraph or Section: N/A ☐
Cancellation and nonrenewal	ORS 743.560, ORS 743.565, OAR 836-052-0800 to 0860	Required minimum grace period and notice of termination requirements.	Page: Paragraph or Section:
	ORS 743.560(3)	Notification of non-replacement rights is sent to the policyholder no later than 10 days after the termination date.	Page: Paragraph or Section:
	ORS 743.565	The policy provides that an insurer seeking to terminate a policy for nonpayment of premium will notify the policyholder at least 10 days prior to the end of the grace period.	Page: Paragraph or Section:

Category	Reference	Description of review standards requirements	Answer
Chemical dependency and mental or nervous conditions	ORS 743A.168, OAR 836-053-1404, OAR 836-053-1405, 29 CFR §2590.712, 45 CFR §146.136, 45 CFR §147.160	A group health insurance policy shall provide coverage for expenses arising from treatment for chemical dependency, including alcoholism, and for mental or nervous conditions at the same level as, and subject to limitations no more restrictive than, those imposed on coverage or reimbursement of expenses arising from treatment for other medical conditions.	Page: Paragraph or Section:
		The policy and certificate must contain a statement of compliance that indicates the policy is compliant with federal mental health parity.	Page: Paragraph or Section:
		We will no longer allow the 45 day limit on residential treatment programs. 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) – are clear this arbitrary quantitative limit applied only to mental health and chemical dependency is not allowed.	Confirmed ☐
		House Bill 2385 (2013 session) removed the previously-allowed exclusion listed in ORS 743A.168(4)(a) (Mental health/chemical dependency mandate) for court-ordered screening interviews or treatment programs when a person is convicted of driving under the influence of intoxicants (DUII). These are no longer allowed to be excluded.	Confirmed ☐
Children	ORS 743.847(6)	An insurer may not deny enrollment of a child under the group or individual 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 ☐
Children with pervasive developmental disorder	ORS 743A.190	A health benefit plan must cover for a child enrolled in the plan who is under 18 years of age and who has been diagnosed with a pervasive developmental disorder all medical services, including rehabilitation services, that are medically necessary and are otherwise covered under the plan.	Page: Paragraph or Section:
Claim procedures	OAR 836-080-0230 and -0235, 29 CFR 2560.503-1, 45 CFR 147.136	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:
Clinical social worker	ORS 743A.024*	Coverage provides reimbursement for any service that is within the lawful scope of practice of a licensed clinical social worker, if the policy provided benefits when a physician or psychologist performed the service and a physician or psychologist referred the insured to the licensed clinical social worker.	Page: Paragraph or Section:

Category	Reference	Description of review standards requirements	Answer
Clinical trials	ORS 743A.192, 42 USC §300gg–8	Health benefit plans must cover the routine costs of care for patients enrolled and participating in qualifying clinical trials.	Page: Paragraph or Section:
		The policy and certificate must comply with both Oregon and federal clinical trial mandates.	Confirmed ☐
		Oregon mandate:	
		Health benefit plans shall provide coverage for the routine costs of the care of patients enrolled in and participating in approved clinical trials. *"Routine costs" means all medically necessary conventional care, items, or services consistent with the coverage provided by the health benefit plan if typically provided to a patient who is not enrolled in a clinical trial.*	Page: Paragraph or Section:
		Health benefit plans may not exclude, limit, or impose additional conditions on the coverage of the routine costs for items and services furnished in connection with participation in an approved clinical trial.	Confirmed ☐
		Health benefit plans may not include provisions that discriminate against an individual on the basis of the individual's participation in an approved clinical trial.	Confirmed ☐
		Federal mandate:	
		A qualified individual is someone who is eligible to participate in an approved clinical trial and either the individual's doctor has concluded that the participation is appropriate or scientific information established that their participation is appropriate.	Page: Paragraph or Section:
		The ACA requires that if a "qualified individual" is in an "approved clinical trial," the plan cannot deny coverage for related services. Plans are not required to cover treatments that fall outside the designated class of approved clinical trials, and plans may not deny coverage because a member is participating in an approved clinical trial conducted outside of the state in which the member lives.	Page: Paragraph or Section:
		A "qualified individual" is someone who is eligible to participate in an "approved clinical trial".	Page: Paragraph or Section:
		An "approved clinical trial" is defined as a Phase I, II, III, or IV clinical trial for the prevention, detection, or treatment of cancer or other life-threatening condition or disease. ***(The Oregon mandate does not limit clinical trials to just these items.)***	Page: Paragraph or Section:
		Expenses include routine patient costs which include all items and services consistent with the coverage provided in the plan that is typically covered for a qualified individual who is not enrolled in a clinical trial.	Page: Paragraph or Section:

Category	Reference	Description of review standards requirements	Answer
Clinical trials, continued	ORS 743A.192, 42 USC §300gg–8	If a participating provider is participating in an approved clinical trial, the plan may require the individual to participate in the trial through that participating provider if the provider will accept the individual as a participant in the trial.	Page: Paragraph or Section:
Colorectal cancer screenings and laboratory tests	ORS 743A.124	An insurer shall provide coverage for all colorectal cancer screening examinations and laboratory tests assigned either a grade of A or B by the United States Preventive Services Task Force. If an insured 50 years of age or older, an insurer may not impose cost sharing on the coverage required above and the coverage shall include, at a minimum: A. Fecal occult blood tests; B. Colonoscopies, including the removal of polyps during a screening procedure; or C. Double contrast barium enemas.	Page: Paragraph or Section:
Continuation of coverage	ORS 743.766, OAR 836-053-0440, 42 USC 300gg-42	Provisions offering replacement coverage to covered individuals who are losing eligible-dependent status.	Page: Paragraph or Section:
	ORS 743.529(1), OAR 836-082-0055	Provides continuation of coverage for a covered hospitalized individual if policy is canceled and immediately replaced by another insurance carrier.	Page: Paragraph or Section:
	ORS 743.529(2), OAR 836-082-0050 to -0055	Provides uninterrupted coverage when the existing policy is replaced.	Page: Paragraph or Section:
Contraceptives	ORS 743A.066, 45 CFR §147.131	Prescription drug benefits provide coverage for oral contraceptives and related services. HRSA Guidelines require coverage, without cost sharing, for all Food and Drug Administration (FDA) approved contraceptive methods, sterilization procedures, and patient education and counseling for all women with reproductive capacity, as prescribed by a provider. *Services related to follow-up and management of side effects, counseling for continued adherence, and device removal are included under the HRSA Guidelines and required to be covered (that is, without cost-sharing, subject to reasonable medical management).*	Page: Paragraph or Section:
Coordination of benefits	ORS 743.552, OAR 836-020-0770 to -0806	If policy applies coordination of benefits, it complies with ORS 743.552 and OAR 836-020-0770 to -0806.	Page: Paragraph or Section:
		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:
Craniofacial anomaly treatment	ORS 743A.150	All health benefit plans 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:

Category	Reference	Description of review standards requirements	Answer
Dentist	ORS 743A.032*	If the policy provides for payment of a surgical service, the performance for the insured of such surgical service by any dentist acting within the scope of the dentist's license is compensable if performance of that service by a physician acting within the scope of the physician's license would be compensable.	Page: Paragraph or Section: N/A ☐
Denturist	ORS 743A.028*	If the policy provides coverage for any service that is within the lawful scope of practice of a denturist, the insured under such policy shall be entitled to reimbursement for such service, whether the service is performed by a licensed dentist or a licensed denturist as defined in ORS 680.500.	Page: Paragraph or Section: N/A ☐
Dependents to age 26	ORS 743A.090(5)(a), 45 CFR §147.120	If a policy offers dependent coverage, it must include dependent coverage until age 26. 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.	Page: Paragraph or Section:
Diabetes management for pregnant women	ORS 743A.082	A health benefit plan 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 during the period of each pregnancy, beginning with conception and ending six weeks postpartum. • This does not apply to a high deductible health plan described in 26 U.S.C. 223. • The coverage required may be limited by network and formulary restrictions that apply to other benefits under the plan. Required coverage does not apply to services, medications, test strips and syringes that are not covered due to the network or formulary restrictions. An insurer may require an enrollee or the enrollee's health care provider to notify the insurer orally, in a timely manner, that the enrollee is diabetic and is pregnant or has given birth and is within six weeks postpartum.	Page: Paragraph or Section:
Discretionary clauses	ORS 742.005(2)(3)(4)	If plan includes a discretionary clause, it does not give the insurer the right to interpret the contract that is legally superior to that of the insured. Discretionary clauses are determined to be prejudicial, unjust, unfair, and inequitable under ORS 742.005(3) and (4). Because such clauses may also reduce an insurer's incentive to draft contracts unambiguously, contracts containing discretionary clauses may also be impermissible under ORS 742.005(2).	Yes ☐ N/A ☐

Category	Reference	Description of review standards requirements	Answer
Discrimination	ORS 746.015, OAR 836-080-0055	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, in the availability of insurance, in the application of rates for insurance, in the dividends or other benefits payable under insurance policies, or in any other terms or conditions of insurance policies.	Confirmed ☐
Domestic partners	ORS 106.300 to 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." Requirements beyond this are not allowed for same sex domestic partners. Any time that coverage is extended to a spouse it must also extend to a domestic partner.	Page: Paragraph or Section:
Eligibility not based on health	ORS 743.754(1), 45 CFR §146.121, 45 CFR §147.110, 45 CFR §147.145(a)(2)	Eligibility is not based on any health status or related factors relating to a student (or a dependent of a student).	Confirmed ☐
Eligibility not based on Medicaid	ORS 743.847(2)	A health insurer is prohibited from considering the availability or eligibility for medical assistance in this or any other state under Medicaid when considering eligibility for coverage or making payments under its group or individual plan for eligible enrollees, subscribers, policyholders or certificate holders.	Confirmed ☐
Emergency eye care services	ORS 743A.250	Any insurer that offers a health benefit plan that provides coverage of eye care services shall allow any enrollee to receive covered eye care services on an emergency basis without first receiving a referral or prior authorization from a primary care provider.	Page: Paragraph or Section: N/A ☐
Emergency services	ORS 743A.012(1)(a), 45 CFR §147.138 Emergency services - Definition	Defines "emergency medical condition" as a medical condition 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 place the health of a person, or an unborn child in the case of a pregnant woman, in serious jeopardy; result in serious impairment to bodily functions; result in serious dysfunction of any bodily organ or part; or 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.	Page: Paragraph or Section:

Category	Reference	Description of review standards requirements	Answer
Emergency services, continued	ORS 743A.012(2), 45 CFR §147.138 Emergency services - No prior authorization required	Health benefit plans shall provide coverage without prior authorization for emergency services.	Page: Paragraph or Section:
	ORS 743A.012(3)(b), 45 CFR §147.138 Emergency services - Nonparticipating providers	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:
	ORS 743A.012(4) Emergency services - Information to enrollees	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.	Page: Paragraph or Section:
	ORS 743.804, OAR 836-053-1030(4) Written information to enrollees	The written information required by ORS 743.804 must include the information required by ORS 743A.012, relating to coverage of emergency medical conditions and obtaining emergency services, including a statement of the prudent layperson standard for an emergency medical condition (defined in 743A.012). An insurer may meet the requirement of providing information in 743A.012 by providing adequate disclosure in the information required by 743.804(1) and this referenced rule. An insurer may use the following statement regarding the use of the emergency telephone number 9-1-1, or other wording that appropriately discloses its use: *“If you or a member of your family needs immediate assistance for a medical emergency, call 9-1-1 or go directly to an emergency room.”*	Page: Paragraph or Section:
	ORS 743A.012(5) Emergency services - Use of 9-1-1	An insurer offering a health benefit plan may not discourage appropriate use of 9-1-1 and may not deny coverage for emergency services solely because 9-1-1 was used.	Confirmed ☐

Category	Reference	Description of review standards requirements	Answer
Enrollment periods	45 CFR §147.104(b), 45 CFR §147.145(b)(ii)	Enrollment periods are not required for student health benefit plans. However, a health insurance issuer may choose to restrict enrollment in health insurance coverage to open or special enrollment periods. If there are specific open or special enrollment periods, they must be clearly stated.	Page: Paragraph or Section: N/A ☐
Essential health benefits	OAR 836-053-0008, 45 CFR §147.150	The policy provides essential health benefits (EHB) with no annual or lifetime dollar limits on EHBs and maximum out of pocket limits for EHBs. The essential health benefits cover the following general categories of services: • Ambulatory patient services • Emergency services • Hospitalization • Maternity and newborn care • Mental health and substance abuse disorder services, including behavioral health treatment • Prescription drugs • Rehabilitative and habilitative services and devices • Laboratory services • Preventive and wellness services and chronic disease management • Pediatric services, including oral and vision care	Yes ☐ N/A ☐
Expanded practice dental hygienist	ORS 743A.034	If a policy of insurance covering dental health provides for coverage for services performed by a dentist licensed under ORS chapter 679, the policy must also cover the services when they are performed by an expanded practice dental hygienist, as defined in ORS 679.010, who has entered into a provider contract with the insurer.	Page: Paragraph or Section: N/A ☐
Gender Identity Disorders	ORS 742.005(4), ORS 746.015(1), Bulletin 2012-01 (does not apply to self-insured employers)	Health insurance plans cannot discriminate against people on the basis that the treatment is for gender identity issues. Health insurers must cover medically necessary treatments related to gender identity disorder if those same treatments are covered for other conditions. ***This standard does not apply to self-insured employers per Bulletin 2012-01.***	Confirmed ☐

Category	Reference	Description of review standards requirements	Answer
Gender Identity Disorders, continued	ORS 742.005(4), ORS 746.015(1), Bulletin 2012-01 (does not apply to self-insured employers)	The division would find an insurer has discriminated if an insurer does any of the following: 1) Denies, cancels, limits or refuses to issue or renew an insurance policy on the basis of an insured's or prospective insured's actual or perceived gender identity; 2) Demands or requires a payment or premium that is based in whole or in part on an insured's or prospective insured's actual or perceived gender identity; 3) Designates GI/GD as a preexisting condition for which coverage will be denied or limited; or 4) Excludes all “Gender Identity Disorders.”	Confirmed ☐
Genetic information	45 CFR §146.122	Issuers may not discriminate on the basis of genetic information.	Confirmed ☐
Grace period	ORS 743.560(1)	Provision states that a minimum 10 day grace period is granted for the payment of each premium falling due after the first premium, during which the policy shall continue in force.	Page: Paragraph or Section:
Grievances and appeals	Senate Bill 89 (2011)	The insurer must provide for a grievance process which includes complaints, internal appeals, and external review. The process is triggered when an enrollee files a grievance regarding an adverse benefit determination.	Page: Paragraph or Section:
	ORS 743.801(1)* Adverse benefit determination definition	Include the statutory definition of **Adverse Benefit Determination:** • Denial of eligibility for or termination of enrollment in a health benefit plan; • Rescission or cancellation of a policy or certificate; • Source-of injury exclusion, network exclusion, annual benefit limit or other limitation on otherwise covered items or services; • Determination that a health care item or service is experimental, investigational or not medically necessary, effective or appropriate; or • Determination that a course or plan of treatment that an enrollee is undergoing is an active course of treatment for purposes of continuity of care under ORS 743.854.	Page: Paragraph or Section:
	ORS 743.801(2)* Authorized representative definition	Include the statutory definition of **Authorized Representative**: An individual who by law or by the consent of a person may act on behalf of the person.	Page: Paragraph or Section:

Category	Reference	Description of review standards requirements	Answer
Grievances and appeals, continued	ORS 743.801(4)* Grievance definition	Include the statutory definition of **Grievance:** A request submitted by an enrollee or an authorized representative of an enrollee expressing dissatisfaction with an adverse benefit determination, without specifically declining any right to appeal or review, that is: • In writing, for an internal appeal or an external review; or In writing or orally, for an expedited response described in ORS 743.804(2)(d) or an expedited external review; or • A written complaint submitted by an enrollee or an authorized representative of an enrollee regarding the: o Availability, delivery or quality of a health care service; o Claims payment, handling or reimbursement for health care services and, unless the enrollee has not submitted a request for an internal appeal, the complaint is not disputing an adverse benefit determination; or o Matters pertaining to the contractual relationship between an enrollee and an insurer.	Page: Paragraph or Section:
	ORS 743.804, OAR 836-053-1030(1) Written information to enrollees	Each insurer must furnish written information to policyholders that is required by ORS 743.804, including but not limited to information relating to enrollee rights and responsibilities, including the right to appeal adverse benefit determinations, services, access thereto and related charges and scheduling, and access to external review. An insurer: a) Must furnish the information regarding an individual health insurance policy to each policyholder; and b) Must furnish the information regarding a group health insurance policy to the group policyholder for distribution to enrollees of the group policy.	Page: Paragraph or Section:
	OAR 836-053-1030(2)	The written information described above must be included either in the policy or in other evidence of coverage that is delivered by the insurer to the group policyholder for distribution to enrollees.	Page: Paragraph or Section:

Category	Reference	Description of review standards requirements	Answer
Grievances and appeals, continued	OAR 836-053-1030(3)	The information required by ORS 743.804 must include the following in relation to referrals for specialty care, behavioral health services, hospital services and other services, in addition to other relevant information regarding referrals: a) If applicable, how gate keeping or access controls apply to referrals and whether and how the controls differ for specialty care, behavioral health services and hospital services; and b) Any limitation on referrals if a plan has a defined network of participating providers and if referrals for specialty care may be limited to a portion of the network, such as to those specialists who contract with an enrollee's primary care group.	Page: Paragraph or Section: N/A ☐
	OAR 836-053-1030(5)	Grievance and appeal process information must be contained in a separate section and captioned in a manner that clearly indicates that the section addresses grievances and appeals.	Page: Paragraph or Section:
	Internal appeals	**The following must be disclosed:**	
	OAR 836-053-1100(1)	An insurer must acknowledge receipt of an appeal from an enrollee not later than the seventh day after receiving the appeal.	Page: Paragraph or Section:
	OAR 836-053-1100(2)	An insurer must make a decision on the appeal not later than the 30th day after receiving notice of the appeal.	Page: Paragraph or Section:
	ORS 743.804(2)(d), OAR 836-053-1100(3)	The insurer will expedite internal appeal(s) when required by clinical urgency and provide a clear explanation of the procedure for requesting expedited review.	Page: Paragraph or Section:
	ORS 743.804(2)(e)(A)	When an insurer provides two levels of internal appeal, a person involved in the initial denial or the first level of appeal may not be involved in the second level.	Page: Paragraph or Section: N/A ☐
	ORS 743.804(2)(e)(B)	When an insurer provides one level of internal appeal, a person involved in the initial denial may not be involved in the internal appeal.	Page: Paragraph or Section: N/A ☐
	ORS 743.804(2)(h)	An enrollee may authorize a representative to act on the enrollee's behalf during the appeal.	Page: Paragraph or Section:

Category	Reference	Description of review standards requirements	Answer
Grievances and appeals, continued	ORS 743.804(2)(h)(A)	An enrollee or their authorized representative has the right to submit additional comments, documents, records, and other material relating to the adverse benefit determination for consideration.	Page: Paragraph or Section:
	ORS 743.804(2)(h)(B)	An enrollee may receive, free of charge, reasonable access to documents used in the adverse benefit determination.	Page: Paragraph or Section:
	OAR 836-053-1100(4)	For adverse benefit determinations eligible for external review under ORS 743.857, an insurer may waive its internal appeals process and move straight to external review.	Page: Paragraph or Section:
	ORS 743.804(1)(b), ORS 743.804(4), OAR 836-053-1030(6), OAR 836-053-1110	Must include a notice that states the right of an enrollee to file a complaint with or seek assistance from the Department of the Consumer and Business Services. Contact information, including the phone number, e-mail address, and mailing address for the division; must also be included.	Page: Paragraph or Section:
	ORS 743.804(2)(g), OAR 836-053-1030(2)(b)	The enrollee must be allowed to receive continued coverage of an approved and ongoing course of treatment pending the conclusion of the internal appeal process. *As used in ORS 743.804(2)(g), "continued coverage under the health benefit plan" means coverage of an ongoing course of treatment previously approved by the insurer.*	Page: Paragraph or Section:
	External review	**The insurer must have a process in place for an external review with an Independent Review Organization (IRO) chosen by the Director. In addition, the following must be disclosed:**	
	OAR 836-053-1030(2)(c)(A)	The insurer must provide an explanation of when external review is available and how to request external review. The description must include the phone number of the Oregon Division of Financial Regulation.	Page: Paragraph or Section:
	OAR 836-053-1340(1)	The insurer must notify the division of an enrollee's request for external review no later than the second business day after receipt of the request.	Page: Paragraph or Section:
	OAR 836-053-1340(10), OAR 836-053-1342(4)	An IRO must complete their review within: • 3 days for expedited reviews (notification is immediate) • 30 days when not expedited (notification within 5 days)	Page: Paragraph or Section:
	ORS 743.857(1)	An external review must be provided when there is a dispute on an adverse benefit determination regarding whether a course or plan of treatment is: • medically necessary • experimental or investigational • an active course of treatment for purposes of continuity of care under ORS 743.854 • delivered in an appropriate health care setting and with the appropriate level of care	Page: Paragraph or Section:

Category	Reference	Description of review standards requirements	Answer
Grievances and appeals, continued	ORS 743.857(2)	The insurer shall pay the cost of the external review.	Page: Paragraph or Section:
	ORS 743.861(1)(a), OAR 836-053-1030(2)(c)(B)	A disclosure that when filing a request for an external review the enrollee will be required to authorize the release of any records, including medical records of the covered person that may be required to be reviewed for the purpose of reaching a decision on the external review.	Page: Paragraph or Section:
	ORS 743.857(4)	The enrollee may submit additional information to the IRO no later than 5 business days after the appointment of the IRO or 24 hours in the case of an expedited review.	Page: Paragraph or Section:
	ORS 743.857(5)	The insurer and the director shall expedite the external review in the case of clinical urgency and the insurer must explain the circumstances in which external review can be expedited.	Page: Paragraph or Section:
	ORS 743.861(1)	A description of the circumstances in which the enrollee can move to external review and bypass internal appeals.	Page: Paragraph or Section:
	OAR 836-053-1030(2)(c)(C)	A disclosure that the enrollee is financially responsible for benefits paid to or on behalf of an enrollee pursuant to ORS 743.804(2)(g) if the insurer's adverse benefit determination is upheld on appeal.	Page: Paragraph or Section:
	OAR 836-053-1030(2)(c)(D)	A disclosure that the enrollee may request and receive from the insurer the information the insurer is required to disclose under ORS 743.804(5).	Page: Paragraph or Section:
	ORS 743.859	The following in boldfaced type or otherwise emphasized: • The enrollee has the right to external review. • The insurer is bound to follow the decision of the IRO, and may be penalized by DCBS if it fails to do so. • The enrollee has the right to sue the insurer if the decision of the IRO is not implemented.	Page: Paragraph or Section:
	ORS 743.804(5), OAR 836-053-1030(12) Additional information upon request	**Insurers must disclose that the following additional information is available upon request:**	
		The notice must include the name and telephone number of the insurer's administrative section that handles enrollee requests for information. The notice must also include DFR contact information (as required by OAR 836- 053-1030(6)).	Page: Paragraph or Section:
		Since DFR unveiled a new website in early 2014, the URL listed in OAR 836- 053-1030(6) is incorrect and must be changed to http://www.oregon.gov/DCBS/insurance/gethelp/Pages/fileacomplaint.aspx. We will be doing future rulemaking to update this link in the rule.	Page: Paragraph or Section:

Category	Reference	Description of review standards requirements	Answer
Grievances and appeals, continued	ORS 743.804(5), OAR 836-053-1030(12) Additional information upon request	**The notice also must 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	Page: Paragraph or Section:
		Annual summary of utilization review policies	Page: Paragraph or Section:
		Annual summary of quality assessment activities	Page: Paragraph or Section:
		Results of all publically available accreditation surveys	Page: Paragraph or Section:
		Annual summary of the insurer's health promotion and disease prevention activities	Page: Paragraph or Section:
		Annual summary of scope of network and accessibility of services	Page: Paragraph or Section:
Hearing aids for children	ORS 743A.141	A health benefit plan shall provide payment, coverage, or reimbursement for one hearing aid per hearing impaired ear if: (a) Prescribed, fitted and dispensed by a licensed audiologist with the approval of a licensed physician; and (b) Necessary for the treatment of hearing loss in an enrollee who is: A. 18 years of age or younger; or B. 19 to 25 years of age and enrolled in a secondary school or an accredited educational institution. The maximum benefit amount required by this section is $4,000 every 48 months, but a health benefit plan may offer a benefit that is more favorable to the enrollee. The benefit amount shall be adjusted on January 1 of each year to reflect the increase in the U.S. City Average Consumer Price Index for All Urban Consumers for medical care as published by the Bureau of Labor Statistics of the United States Department of Labor. ***Annual dollar limits must be converted to a non-dollar actuarial equivalent.***	Page: Paragraph or Section:
HIPAA requirements	45 CFR Part 160, 45 CFR Part 164	Policy meets all HIPAA Privacy requirements and all HIPAA-related statements are solely supported by HIPAA requirements.	Confirmed ☐

Category	Reference	Description of review standards requirements	Answer
HPV vaccine	ORS 743A.105	All health benefit plans shall include coverage of the human papillomavirus vaccine for female beneficiaries under the health benefit plan who are at least 11 years of age but no older than 26 years of age.	Page: Paragraph or Section:
Inborn errors of metabolism	ORS 743A.188	All plans shall include coverage for treatment of inborn errors of metabolism that involve amino acid, carbohydrate and fat metabolism and for which medically standard methods of diagnosis, treatment and monitoring exist, including quantification of metabolites in blood, urine or spinal fluid or enzyme or DNA confirmation in tissues. Coverage shall include expenses of diagnosing, monitoring and controlling the disorders by nutritional and medical assessment, including but not limited to clinical visits, biochemical analysis and medical foods used in the treatment of such disorders.	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 ☐
Inmate coverage pre-adjudication	House Bill 4110 (2014)	For services provided on or after 1/1/2015, an insurer offering a health benefit plan may not deny reimbursement for any service or supply covered by the plan or cancel the coverage of an insured under the plan on the basis that: a) The insured is in the custody of a local supervisory authority, if the insured is in custody pending the disposition of charges; b) The insured receives publicly funded medical care while in the custody of a local supervisory authority; or c) The care was provided to the insured by an employee or contractor of a county or a local supervisory authority, if the employee or contractor meets the credentialing criteria of the health benefit plan.	Confirmed ☐
Mammogram	ORS 743A.100	Every plan shall provide coverage of mammograms as follows: a) 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 b) 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 or at any time if the woman is determined by her health care provider to be at high risk for breast cancer.	Page: Paragraph or Section:

Category	Reference	Description of review standards requirements	Answer
Mastectomy-related services	ORS 743A.110, 42 U.S.C. 300gg–27	Coverage provides reimbursement for mastectomy-related services that are part of the enrollee's course of treatment including all stages of reconstruction with a single determination of prior authorization. The enrollee is provided a written notice at time of enrollment and annually thereafter describing the coverage for all mastectomy-related services. Include the definition of mastectomy in the contract.	Page: Paragraph or Section:
Maxillofacial prosthetic services	ORS 743A.148	All plans must include coverage for maxillofacial prosthetic services considered necessary for adjunctive treatment.	Page: Paragraph or Section:
Natural and adopted children	ORS 743A.090	All health benefit plans that include dependents shall also provide that the health insurance benefits applicable for children in the family shall be payable with respect to: a) A child of the insured from the moment of birth; and b) An adopted child effective upon placement for adoption.	Page: Paragraph or Section:
Newborns and mothers	ORS 743.823, OAR 836-053-1000(10), 45 CFR §146.130	Coverage provides 48 hours of care for vaginal delivery and 96 hours for caesarian and insurer compliance with the Federal Newborns' and Mothers' Health Protection Act of 1996.	Page: Paragraph or Section:
Nonprescription enteral formula for home use	ORS 743A.070	All policies 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:
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:
Optometrist	ORS 743A.040*, ORS 750.065	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 ☐
Orally administered anticancer medication	ORS 743A.068	A health benefit plan that provides coverage for cancer chemotherapy treatment must provide coverage for a prescribed, orally administered anticancer medication used to kill or slow the growth of cancerous cells on a basis no less favorable than intravenously administered or injected cancer medications that are covered as medical benefits.	Page: Paragraph or Section:

Category	Reference	Description of review standards requirements	Answer
Out of pocket maximum for essential health benefits	42 USC §300gg–6	The ACA requires issuers of health benefit plans to limit out-of-pocket maximums on essential health benefits to $6,600 for self-only coverage and $13,200 for other than self-only coverage. Policies may not include a separate out-of-pocket maximum for mental health or substance abuse benefits. The cost sharing for these benefits must be included in the major medical out-of-pocket maximum.	Page: Paragraph or Section:
Pediatrician access	45 CFR §147.138	If the plan mandates designation of a primary care physician, to the plan must allow the policyholder to designate any willing in-network pediatrician as a child's primary care physician.	Page: Paragraph or Section: N/A ☐
Pelvic and Pap smear examinations	ORS 743A.104	Coverage provides reimbursement for pelvic and Pap smear exams provided annually for women 18 to 64 and any time upon referral of the woman's health care provider.	Page: Paragraph or Section:
Physical examination of breast	ORS 743A.108	Coverage includes a complete and thorough physical examination of the breast, including but not limited to a clinical breast examination, performed by a health care provider to check for lumps and other changes for the purpose of early detection and prevention of breast cancer as follows: a) Annually for women 18 years of age and older; and b) At any time at the recommendation of the woman's health care provider.	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:
Preexisting condition exclusion prohibition	45 CFR §147.108	The policy and certificate do not apply preexisting exclusion periods.	Confirmed ☐
Pregnancy and childbirth expenses	ORS 743A.080, OAR 836-053-0003	All health benefit plans must provide payment or reimbursement for expenses associated with pregnancy care and childbirth. Benefits provided shall be extended to all enrollees, enrolled spouses/domestic partners, and enrolled dependents.	Page: Paragraph or Section:
Prescription drugs	ORS 743A.062	If prescription drug coverage is offered, it 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 ☐
Prescription drug step therapy	House Bill 4013 (2014)	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.	Yes ☐ N/A ☐

Category	Reference	Description of review standards requirements	Answer
Prescription drug synchronization	Senate Bill 1579 (2014)	A health plan that includes prescription drug coverage must implement a synchronization policy for the dispensing of prescription drugs to the plan's enrollees.	Yes ☐ N/A ☐
Prescription eye drops	ORS 743A.065	An insurer offering a health benefit plan that provides coverage for prescription eye drops shall provide coverage for one early refill of a prescription for eye drops to treat glaucoma under certain conditions provided in statute.	Page: Paragraph or Section: N/A ☐
Preventive services	ORS 743.764, 45 CFR §147.130	Non-grandfathered plans must provide coverage without cost-sharing for: Services recommended by the US Preventive Services Task Force • Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention • Preventive care and screenings for infants, children, and adolescents supported by the HRSA • Preventive care and screenings for women supported by the HRSA	Page: Paragraph or Section:
		In addition, non-grandfathered plans must provide the following links in their evidence of coverage: A and B list for preventive services: http://www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm Women's preventive services: http://www.hrsa.gov/womensguidelines/	Page: Paragraph or Section:
Prior authorization requirements	ORS 743.837, OAR 836-053-1200	Policy describes prior authorization and binding periods.	Page: Paragraph or Section:
Professional counselor or marriage and family therapist	ORS 743A.052*	If a group health benefit plan, provides for coverage for services performed by a clinical social worker or nurse practitioner, the plan also must cover services provided by a professional counselor or marriage and family therapist licensed under ORS 675.715 to 675.835 when the counselor or therapist is acting within the counselor's or therapist's lawful scope of practice.	Page: Paragraph or Section: N/A ☐

Category	Reference	Description of review standards requirements	Answer
Prosthetic and orthotic devices	ORS 743A.144, OAR 836-052-1000	Coverage provides for prosthetic and orthotic devices that are medically necessary to restore or maintain the ability to complete activities of daily living or essential job-related activities. The coverage required includes all services and supplies medically necessary for the effective use of a prosthetic or orthotic device, including formulating its design, fabrication, material and component selection, measurements, fittings, static and dynamic alignments, and instructing the patient in the use of the device. The list of prosthetic and orthotic devices and supplies in the Medicare fee schedule for Durable Medical Equipment, Prosthetics, Orthotics and Supplies is adopted for the purpose of listing the devices and supplies for which coverage is required by ORS 743A.144.	Page: Paragraph or Section:
Provider discrimination	42 USC §300gg–5	The policy and certificate do not discriminate against providers acting within the scope of licensure or certification.	Confirmed ☐
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 ☐
Rebates	ORS 746.045(1)	No person shall personally or otherwise offer, promise, allow, give, set off, pay or receive, directly or indirectly, any rebate of or rebate of part of the premium payable on an insurance policy or the insurance producer's commission thereon, or earnings, profit, dividends or other benefit founded, arising, accruing or to accrue on or from the policy, or any other valuable consideration or inducement to or for insurance on any domestic risk, which is not specified in the policy.	Yes ☐ N/A ☐
Representations not warranties	ORS 743.528(1)	A provision that, in the absence of fraud, all statements made by applicants, the policyholder or an insured person shall be deemed representations and not warranties, and that no statement made for the purpose of effecting insurance shall avoid the insurance or reduce benefits unless contained in a written instrument signed by the policyholder or the insured person, a copy of which has been furnished to the policyholder or to the person or the beneficiary of the person.	Page: Paragraph or Section:

Category	Reference	Description of review standards requirements	Answer
Rescissions	ORS 743.754(8), ORS 743.894, OAR 836-053-0825, 45 CFR §147.128	A carrier may not rescind a group health benefit plan unless: (a) The plan sponsor or a representative of the plan sponsor: A. Performs an act, practice or omission that constitutes fraud; or B. Makes an intentional misrepresentation of a material fact as prohibited by the terms of the plan; (b) The carrier provides at least 30 days' advance written notice, in the form and manner prescribed by the department, to each plan enrollee who would be affected by the rescission of coverage; and (c) The carrier provides notice of the rescission to the department in the form, manner and time frame prescribed by the department by rule. Rescissions are defined as any retroactive cancellations of coverage, except for those attributable to failure to pay premiums or contributions. These requirements do not apply to prospective cancellations.	Page: Paragraph or Section:
Same-sex marriages validly performed	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. In addition, same-sex married couples validly married now qualify as spouses under COBRA and state continuation.	Confirmed ☐
State hospitals or state approved program	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.	Confirmed ☐
Student administrative health fees	45 CFR 147.145(c)	A student administrative health fee is a fee charged by the institution of higher education on a periodic basis to students of the institution of higher education to offset the cost of providing health care through health clinics regardless of whether the students utilize the health clinics or enroll in student health insurance coverage. *Student administrative health fees are not considered cost-sharing requirements with respect to specified recommended preventive services.*	Page: Paragraph or Section:
Summary of essential features	ORS 743.528(2)	A provision that the insurer will furnish to the policyholder for delivery to each employee or member of the insured group a statement in summary form of the essential features of the insurance coverage of the employee or member, to whom the insurance benefits are payable, and the applicable rights. If dependents are included in the coverage, only one statement need be issued for each family unit.	Page: Paragraph or Section:

Category	Reference	Description of review standards requirements	Answer
Telemedical services	ORS 743A.058	A health benefit plan must provide coverage of a telemedical health service if: a) The plan provides coverage of the health service when provided in person by the health professional; b) The health service is medically necessary; and c) The health service does not duplicate or supplant a health service that is available to the patient in person.	Page: Paragraph or Section:
Telemedical services for diabetes treatment	ORS 743A.185	A health benefit plan must provide coverage of a telemedical health service provided in connection with the treatment of diabetes if: a) The plan provides coverage of the health service when provided in person by the health professional; b) The health service is medically necessary; c) The telemedical health service relates to a specific patient; and d) One of the participants in the telemedical health service is a representative of an academic health center.	Page: Paragraph or Section:
Tobacco use cessation programs	ORS 743A.170	Coverage to provide payment or reimbursement of at least $500 for tobacco use cessation programs for persons aged 15 years or older who is enrolled in the benefit plan. ***Annual and lifetime dollar limits must be converted to a non-dollar actuarial equivalent.***	Page: Paragraph or Section:
Tobacco use definition	45 CFR §147.102	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 health benefit plan shall provide coverage of medically necessary therapy and services for the treatment of traumatic brain injury.	Page: Paragraph or Section:
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 ☐
Use by mother of diethylstilbestrol	ORS 743A.088	Insurers may not deny issuance or cancel a health insurance policy solely because the mother of the insured used drugs containing diethylstilbestrol prior to the insured's birth.	Confirmed ☐
Women's health care	ORS 743.845(2), 45 CFR §147.138	Whenever a plan requires an enrollee to designate a primary care provider, the plan must permit a female enrollee to designate a woman's health care provider as her primary care provider as defined in ORS 743.845(1).	Page: Paragraph or Section: N/A ☐

Category	Reference	Description of review standards requirements	Answer
Women's health care, continued	ORS 743.845(3), 45 CFR §147.138	Whenever a plan requires an enrollee to designate a primary care provider, the plan must permit a female enrollee to have direct access to a women's health care provider, without a referral or prior authorization, for obstetrical or gynecological care by a participating health care professional who specializes in obstetrics or gynecology.	Page: Paragraph or Section: N/A ☐
Workers' compensation claims	House Bill 4104 (2014)	A carrier may not impose an exclusion or waiver in a health benefit plan for coverage of any service otherwise provided under the plan solely on the basis that the service is provided for a work-related injury or occupational disease.	Confirmed ☐