Department of Consumer & Business Services
Oregon Division of Financial Regulation - 5
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Standard Provisions for Multiple Employer Welfare Arrangements Group Health Benefit Plans

(Subject to ORS 750.301 to 750.341)

This product standards checklist must be submitted with your filing in compliance with OAR 836-010-0011(2). This list includes relevant statutes, rules, 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. Any line left blank will cause this filing to be considered incomplete. Not including required information or policy provisions may result in disapproval of the filing. (*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.*)

Insurer name: _____ **Date:** _____

Type of Insurance: ☐ H16G Group health - Major medical ☐ H15G Hospital/surgical/medical expense

Sub-Type of Insurance:
- ☐ H16G.002A - Large group – PPO
- ☐ H16G.002B - Large group - POS
- ☐ H16G.002C - Large group - Other
- ☐ H16G.003A - Small group only - PPO
- ☐ H16G.003B - Small group only - PPO basic
- ☐ H16G.003D - Small group only - POS
- ☐ H16G.003E - Small group only - POS basic
- ☐ H16G.003G - Small group only - Other (indemnity)

- ☐ H15.0002 – Large group only

Type of group:
- ☐ Large group that meets the definition of a Health Benefit Plan in ORS 743.730(19)(a).
- ☐ Oregon small employer, ORS 743.730(30)(a) and OAR 836-053-0021(1)

****If this filing is a fully-insured group health plan for a Multiple Employer Welfare Arrangement (MEWA), please fill-out product standards 440-2448 (Rev. 09/10/ins)**

GENERAL REQUIREMENTS (FOR ALL FILINGS)			
Review requirements	Reference	Description of review standards requirements	Check 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 for your filing for it to be accepted as complete: 1. Filing description (cover letter). 2. Third party filer's letter of authorization. 3. Certificate of compliance form signed and dated by authorized person. 4. Readability certification. 5. Product standards (this document). 6. If filing for small employer groups (SEHI) include additional requirements and actuarial memorandum at the end of this document. 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. Copy of the trust agreement. 9. Copy of the required notice at time of application. 10. For mailed filings, two self-addressed stamped envelopes, one in which the IDivision of Financial Regulation can return approved forms.	Yes N/A ☐
	Filing description on transmittal form	The filing description (cover letter) includes the following: 1. Exceptions used to modify the mandated design. 2. Changes made to prior approved plan or variations from other approved plans. 3. Summary of the differences between prior approved like form and the new form. 4. The differences between in-network and out-of-network. 5. An explanation of the variability of any information appearing in the forms that is noted as variable. 6. Has the Multiple Employer Welfare Arrangement (MEWA) been approved by meeting all the requirements as contained in ORS 750.305 and granted a certificate of authority (COA) number by the Oregon Division of Financial Regulation	Yes N/A ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
Review requested	ORS 742.003(1), OAR 836-010-0011(3)	The following are submitted in this filing for review: 1. New policy and/or certificate. 2. Amendment of an approved form. 3. Riders, endorsement, applications and advertisements.	Yes N/A ☐ ☐ ☐ ☐ ☐ ☐

Review requirements	Reference	Description of review standards requirements	Check answer
Applicability	Disability and other miscellaneous health coverages	If filing disability coverage, submit Form 440-2447 Standard Provisions for Long and Short Term Disability, Group or Individual. If filing miscellaneous health coverage for a MEWA group: For Dental and Vision submit Form 440-3172A. For Hospital, Prescription Drug, or Sickness submit Form 440-3172B. For Specified Disease, Limited Benefits, or Short Term Care submit Form 440-3172C	
	ORS 743.565, OAR 836-052-0800 to 0860	A separate notice of cancellation is mailed 10 days prior to the end of the grace period.	Yes ☐
	ORS 743A.088	Health coverage is not denied or canceled because insureds mother used drugs containing diethylstilbestrol prior to the insured's birth.	Yes ☐
	ORS 743A.110	The enrollee is provided a written notice at time of enrollment and annually thereafter describing the coverage for all mastectomy-related services including reconstruction of the breast by obtaining a single authorization.	Yes ☐
	ORS 750.323(2)	Each evidence of health benefits provided by the MEWA includes a statement that the coverage is obtained through a MEWA and the benefits are not protected by the Oregon Life and Health Insurance Guaranty Association if the arrangement or the trust issuing the coverage becomes insolvent.	Yes ☐
	ORS 743.758 HIPAA Privacy	Policy meets all HIPAA privacy requirements and all HIPAA-related statements are solely supported by HIPAA requirements.	Yes ☐
Application	OAR 836-053-0510, ORS 743.766	No application with medical questions is used to enlist new enrollees and Form 440-3087 Oregon Health Statement is used for late enrollees.	Yes ☐ N/A ☐
	ORS 743.752(5), 743.736(6)	Eligibility is limited to groups or individuals that are in the same trade, business, profession, industry, or their subsidiaries as that covered by the MEWA.	Yes ☐
		The MEWA accepts all groups and individuals in the same trade, business, profession, industry, or their subsidiaries that apply for coverage that meet the requirements for membership in the arrangement. Requirements cannot include actual or expected health status of the prospective enrollee.	Yes ☐
Clarity/ Readability	ORS 742.005(2)	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.	Confirm ☐
	ORS 743.106(1)(d), ORS 743.103	Policy and certificate contain a table of contents or index of the principal sections if longer than three pages or over 3,000 words.	Yes ☐ N/A ☐

Review requirements	Reference	Description of review standards requirements	Check answer
Form numbers	ORS 742.005(2)	The policy and certificate are filed under one form number and the form provides core coverage with all basic requirements. Basic policy requirements are not bracketed unless an alternative selection is included. Optional benefits to the policyholder are riders or endorsements with separate form numbers. (See guidelines on our Web site: http://dfr.oregon.gov/rates-forms/Pages/index.aspx.)	Yes ☐ N/A ☐
Notice	ORS 750.323	Each individual applying receives a notice in writing of the following: 1. A statement that the MEWA is subject to less stringent solvency protection and regulation than insurers holding a certificate of authority. 2. A statement that in the event the trust does not pay for eligible medical expenses, the individuals covered may be liable for those expenses.	Yes ☐
Variable text	ORS 742.003(1), ORS 742.005(2)	Variable data is indicated by brackets and all variable ranges or options are identified. (*Variable data may be included within the policy and certificate or may be submitted as an attachment known as "Statement of Variability' (SOV)*) The SOV must provide ample explanation of variable data inside each bracket. It should also contain points of reference tracking back to the form being reviewed. These points of reference could be page numbers, section numbers, or paragraph descriptions.	Yes ☐ N/A ☐
GENERAL FORMS REQUIREMENTS			
Cover page	National standards	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 two company officers appears on the first page of the policy. 5. The individual certificate includes a right-to-examine provision that appears on the cover page of the certificate. 6. 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 other forms used. 7. The policy contains a brief caption that appears prominently on the cover page and describes the type of coverage.	Yes ☐ N/A ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

POLICY AND CERTIFICATE PROVISIONS			
Review requirements	Reference	Description of review standards requirements	Page & paragraph
Ambulance	ORS 743A.014	If ambulance care and ground transportation to the nearest hospital is covered, coverage payments are either made directly to the provider or jointly to the insured and the provider.	
Benefit reimbursement	ORS 743A.010 State hospital	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.	
	ORS 743A.024 Social worker	Coverage provides reimbursement for any service that is within the lawful scope of practice of a licensed clinical social worker and a physician or psychologist referred the insured to the licensed clinical social worker, if the policy provided benefits when a physician or psychologist performed the service.	
	ORS 743A.032 Dentist	Coverage provides reimbursement for any service that is within the lawful scope of practice of a licensed dentist, if policy provided benefits when a physician performed the service.	
	ORS 743A.036 Nurse Practitioner	Coverage provides reimbursement for any service that is within the lawful scope of practice of a duly licensed and certified nurse practitioner, if the policy provided benefits when a physician performed the service.	
	ORS 743A.040, 750.065 Optometrist	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.	
	ORS 743A.044 Physician Assistant	Claims submitted directly by physician assistants, practicing in keeping with ORS 677.515(4), to be paid as if submitted by the supervising physician.	
	ORS 743A.048 Psychologist	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.	
	ORS 743A.052 Marriage and family therapist	If the MEWA health benefit plan provides 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.	

Review requirements	Reference	Description of review standards requirements	Page & paragraph
Benefit reimbursement, continued	ORS 743A.058 Telemedical services	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. See statute for definitions.	
	ORS 743A.080 Pregnancy and childbirth	Coverage provides reimbursement for expenses associated with pregnancy care, as defined by ORS 743.845, and childbirth. Benefits provided under this section shall be extended to all enrollees, enrolled spouses, and enrolled dependents.	
	ORS 743A.100 Mammogram	Coverage provides for annual mammogram reimbursement for the purpose of early detection and any time if high risk for women over 40; more frequent reimbursement if the health care provider determines a woman is at high risk for breast cancer.	
	ORS 743A.104 Pelvic and Pap	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.	
	ORS 743A.105 HPV vaccine	All health benefit plans, as defined in ORS 743.730, shall include coverage of the human papilloma virus (HPV) 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.	
	ORS 743A.110 Mastectomy	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.	
	ORS 743A.141 Hearing aids	A health benefit plan, as defined in ORS 743.730, 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 in the plan who is: (A) Under 18 years of age; or (B) 18 years of age or older, eligible as a dependent under the plan and enrolled in an accredited educational institution.	
	ORS 743A.148 Maxillofacial	Coverage includes maxillofacial prosthetic services necessary for adjunctive treatment.	
	ORS 743A.168, OAR 836-052-0225 to 0230 Treatment of chemical dependency	Coverage provides reimbursement for hospital or medical expenses arising from treatment for chemical dependency including alcoholism and for mental or nervous conditions and specifies the amount of coverage required.	

Review requirements	Reference	Description of review standards requirements	Page & paragraph
Benefit reimbursement, continued	ORS 743A.170 Tobacco cessation	A health benefit plan as defined in ORS 743.730 must provide payment, coverage or reimbursement of at least $500 for a tobacco use cessation program for a person enrolled in the plan who is 15 years of age or older.	
	ORS 743A.175 Traumatic brain injury	A health benefit plan, as defined in ORS 743.730, shall provide coverage of medically necessary therapy and services for the treatment of traumatic brain injury.	
	ORS 743A.184 Diabetes self-management programs	Coverage provides reimbursement for supplies, equipment; and diabetes self-management programs associated with the treatment of diabetes prescribed by a health care professional.	
	ORS 743A.0188 Inborn errors	Coverage includes treatment of inborn errors of metabolism that involve amino acid, carbohydrate, and fat metabolism.	
	ORS 743A.192 Clinical trials	A health benefit plan, as defined in ORS 743.730, shall provide coverage for the routine costs of the care of patients enrolled in and participating in qualifying clinical trials.	
Cancellation and nonrenewal	ORS 743.560(4), OAR 836-052-0800 to 0860	Notice upon termination if coverage is not replaced by the policyholder. This requirement includes an employer's participation in or the termination of a multiple-employer trust policy.	
	ORS 743.560(3)	Notification of non-replacement rights is sent to the policyholder no later than 10 days after the termination date.	
	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.	
Claims settlement	ORS 743.804(3), OAR 836-053-1100	The contract contains a timely and organized system for resolving grievances and appeals.	
	ORS 743.857(1)(a)(b)(c), ORS 743.859(1)(2)(3), ORS 743.861(1)	Includes external review program that meets requirements of ORS 743.857(1)(a), (b), or (c); ORS 743.859(1)(2) or (3); and ORS 743.861(1).	
Continuation of coverage	ORS 743.854(9)(10) Continuity of care	"Continuity of care" is a health benefit plan feature under which an enrollee who is receiving care from an individual provider is entitled to continue with care with the individual provider for a limited period of time after the medical services contract terminates.	
	ORS 743.527 (1)(a) Strikes or lockouts	Provides continuation of coverage for strike or lockouts.	
	ORS 743.529(1), OAR 836-082-0055	Provides continuation of coverage for a covered hospitalized individual if policy is canceled and replaced by another insurance carrier.	

Review requirements	Reference	Description of review standards requirements	Page & paragraph
Continuation of coverage, continued	ORS 743.529(2), OAR 836-082-0050 to 0055	Provides uninterrupted coverage when the existing policy is terminated or replaced.	
	ORS 743.530 Workers Compensaion	Provides continuation of coverage after injury or illness claim filed for workers' compensation.	
	ORS 743.600, ORS 743.601, ORS 743.602 Continuation	Provides continuation of coverage for surviving, divorced, or separated spouse age 55 or older for employers with 20 or more employees.	
	ORS 735.616(2)(c)(B) OMIP	Includes state eligibility requirements to obtain an individual portability plan.	
Coordination of benefits	ORS 743.549	If policy applies coordination of benefits, it complies with ORS 743.549, ORS 743.552, and OAR 836-020-0700 to 0765.	
		Reduction of benefit payments on the basis of other insurance for the insured individual is in full accordance with coordination-of-benefits rules.	
Credibility	ORS 742.005(2)(3) Discretionary clauses	If plan includes a discretionary clause, it does not give the MEWA full and final discretion in interpreting its insurance contract. (Such a clause is considered to be inequitable to consumers.)	
Definitions	ORS 750.301 MEWA Definition	Does the definition of Multiple Employer Welfare Arrangement (MEWA) reflect that of the definition given to that term in section 3 of the Federal Employee Retirement Income Security Act of 1974 (ERISA) as amended, 29 U.S.C 1002?	
	ORS 743.801(5), OAR 836-053-1060 Grievance and appeals	Definition of "grievance" as they apply to the grievance/complaints procedures.	
	ORS 743.730(8), Creditable coverage	Creditable coverage is defined per OAR 836-053-0230 or OAR 836-053-0060.	
	ORS 743.730(12), OAR 836-053-0021 Eligible employee	Eligible employee definition meets the requirements of ORS 743.730(12) and OAR 836-053-0021.	
	ORS 743.730(14) Enrollee	Definition of "enrollee" includes employee, dependent of the employee, or an individual otherwise eligible under the group.	
	ORS 743.730(15), OAR 836-053-0250 Exclusion period	Describes exclusion period.	
	ORS 743.730 (19) Health benefit plan	The policy defines health benefit plan.	
	ORS 743.730(24) Late enrollee	Defines "late enrollee" as an individual who enrolls in the group subsequent to the initial enrollment period during which the individual was eligible for coverage.	

Review requirements	Reference	Description of review standards requirements	Page & paragraph
Definitions, continued	ORS 743.730(27) Pre-existing condition	Defines "pre-existing condition" as services, charges, or expenses incurred for pre-existing conditions for specified period immediately following enrollment, for which medical advice, diagnosis, care, or treatment was recommended or received during a specified period immediately preceding enrollment. (*Pre-existing conditions do not include:* *1. Pregnancy, except as provided in ORS 743.766.* *2. Genetic information in the absence of a diagnosis.* *3. A newborn child or adopted child who obtains coverage in accordance with ORS 743A.090.*)	
	ORS 742.023(1)(f), (ORS 742.065 SEHI)	Stop-loss or out-of-pocket provisions define calendar year and contract year. The definition follows the administration of these provisions and clearly states how the crediting for previously satisfied deductibles, stop-loss, or out-of-pocket maximum is applied on mid-year contract renewal.	
Dependent coverage	ORS 743A.090 Newborn children	Policy covers newborn children of the insured and/or qualified eligible dependents from the moment of birth. Covers adopted children of the insured from the date of placement of the children with the insured for adoption.	
	ORS 743.847(6)(a)(b)(c) Dependent children	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.	
	Bulletin 2008-02, ORS 106.305(4) Registered same sex domestic partnerships	The contract recognizes same sex domestic partners as spouse, for the purpose of insuring dependence. All the benefits offered to married spouses must be offered to register same sex domestic partners. See bulletin 2008-02 at: http://www.cbs.state.or.us/external/ins/bulletins/bulletin2008-02.html	
Discrimination	ORS 743A.084 Unmarried women	Policy provides the same payments for costs of maternity to unmarried women that it provides to married women and the same coverage for the child of an unmarried woman that the child of an insured married person choosing family coverage receives.	
	ORS 746.015(1)(2)(3) Physical disabilities, age 65, domestic violence victims	ORS 746.015 prohibits the practice of discrimination due to physical disabilities, attaining or exceeding age 65, and victims of domestic violence, unless this practice is based on sound actuarial principles or is related to actual and reasonable anticipated experience.	
Eligibility	ORS 743.837, OAR 836-053-1200	Policy describes prior authorization and binding periods.	

Review requirements	Reference	Description of review standards requirements	Page & paragraph
Emergency care	ORS 743.801(1)(2)(3)	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 fetus, in the case of a pregnant woman, in serious jeopardy.	
	ORS 743A.012	Emergency services are not subject to additional penalty or pre-authorization requirements.	
Exclusions	ORS 743.847(2)	Eligibility for benefits is not determined based on eligibility for Medicaid.	
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.	
Managed care	ORS 743.845(2)(3) Women's health care providers	Provision allows for the designation of a women's health care provider as the primary care physician, if a primary care physician is required. The contract also allows a female enrollee to designate a women's health care provider as her primary care provider. Contract provision must also permit a female enrollee to have direct access to a women's health care provider for at least one annual preventive women's health examination and for pregnancy care.	
	ORS 743.821 Required managed health care contract provisions	All insurers offering managed health insurance shall include in their providers contracts a provision requiring that in the event the insurer fails to pay for health care services covered by the health benefit plan, the provider shall not bill or otherwise attempt to collect from enrollees for amounts owed by insurers, and enrollees shall not be liable to the provider for any sums owed by the insurer.	
	ORS 743.808(1)(a) Participating primary care physician	All insurers offering a health benefit plan that requires an enrollee to designate a participating primary care physician shall permit the enrollee to change participating primary care physicians at will.	
	ORS 743.842(2) Emergency eye care services	A health benefit plan providing 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.	
Pre-existing conditions	ORS 743.754(1)(2)	The pre-existing condition provisions apply only to conditions for which medical advice, diagnosis, care, or treatment was recommended or received during the six-month period prior to enrollment; they terminate on the earlier of six months following effective date for new enrollees or 12 months for late enrollees.	
	ORS 743.754(3), OAR 836-053-0230, OAR 836-053-0040	Credit for covered time reduces the pre-existing condition period when creditable coverage ended within 63 days of the enrollment date.	
Proof of loss	OAR 836-080-0230 and 023	If the policy includes claim procedures, the procedures and timelines comply with fair claim practice requirements.	

Review requirements	Reference	Description of review standards requirements	Page & paragraph
Requirements not part of a listed category	ORS 743A.084	Policy provides the same payments for costs of maternity to unmarried women that it provides to married women and the same coverage for the child of an unmarried woman that the child of an insured married person choosing family coverage receives.	
	ORS 743.823, OAR 836-053-1000(10)	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.	
	ORS 743.829 Hospital stays	An insurer may not terminate or restrict the practice privileges of any provider solely on the basis of one or more decisions made regarding length of stay in a health care facility as defined in ORS 442.015, transfer between levels of care and follow-up care, as those decisions shall by made the treating provider in consultation with the patient, as appropriate.	
Renewability	ORS 743.754(6), (ORS 743.737(5) SEHI)	Describes renewal, modification, or discontinuance provisions.	
Usual, customary, or reasonable	ORS 743.878	The contract discloses the claim methodology used to pay members for claims filed.	
Utilization review	ORS 743.807(2)	If the contract provides utilization review, it complies with all requirements (prior authorization and appeal process) under OAR 836-053-1140.	
Vision	ORS 743.842	If the plan covers eye care services, the benefit includes emergency eye services.	
Waiting period	ORS 743.730(18)	Policy describes group eligibility waiting period.	
	ORS 743.754(3)(a)	Policy describes the affiliation period limitation for health care service contractors on pre-existing conditions.	
	ORS 743.754(3)(b), OAR 836-053-0250	Policy describes the exclusion period for specified covered services and its application to all individuals enrolling for the first time in the group health benefit plan.	
	ORS 743.754(4) Late enrollees	Are late enrollees excluded from coverage or subjected to a pre-existing condition provision? If so, an exclusion from coverage period and a preexisting condition provision are applicable but the combined period may not exceed 12 months.	
	ORS 743.754(5) Enrollment period	The group health benefit plan contract must contain special enrollment periods during which eligible employees and dependents may enroll for coverage, as provided in 42 U.S.C. 300gg as amended and in effect on July 1, 1997.	

(Attach if filing for small employer groups)

ADDITIONAL STANDARDS FOR SMALL EMPLOYER GROUPS (OAR 836-053-0070)			
Review requirements	Reference	Description of review standards requirements	Page & paragraph
Applicability	ORS 743.736(2), OAR 836-053-0060	The SEHI basic indemnity or health benefit plan referenced in OAR 836-053-0060.	
Continuation of coverage	ORS 743.610 State continuation	Provision describes continuation of coverage requirement for employers with less than 20 employees.	
Dependent coverage	ORS 743.737, OAR 836-053-0060	Coverage includes immunizations. Coverage also includes a brief examination of primary care, vision, and hearing as follows: 1. Birth to 24 months, well-baby care, up to eight exams 2. Ages 24 months to six years, one exam each year 3. Ages 6 to 18 years, one exam every two years	
Eligibility	ORS 743.737(13)(14) Dependents enrollment periods	The MEWA contract includes provisions that cover all eligible employees and dependents, if chosen by the small employers in the trust and provides for special enrollment periods for eligible employees and their dependents to enroll.	
Preexisting conditions	ORS 743.737(1)(2)	The pre-existing condition provisions apply only to conditions for which medical advice, diagnosis, care, or treatment was recommended or received during the six-month period prior to enrollment; they terminate on the earlier of six months following effective date for new enrollees or 12 months for late enrollees.	
	ORS 743.737(3) SEHI plans	In applying a pre-existing condition provision to an enrollee or late enrollee, all small employer health benefit plans shall reduce the duration of the provision by an amount equal to the enrollee's or late enrollee's aggregate periods of creditable coverage if the most recent period of creditable coverage is ongoing or ended within 63 days of the enrollment date in the new small employer health benefit plan.	
Hospital/surgical /medical expenses	ORS 743A.080 OAR 836-053-60 Pregnancy and maternity Expenses	Small employer groups provide hospital inpatient services that include: 1. Delivery, post-partum, newborn care per ORS 743.823. 2. Anesthesia 3. Medical supplies, drugs and medications, orthotics 4. Durable medical equipment 5. Functional medical equipment (e.g. pacemakers or artificial joints) 6. Blood or blood products 7. Rehabilitation care for disease or injury, maximum 30 days per condition except in cases of head or spinal cord injury, which have a maximum 60 days per condition.	

Review requirements	Reference	Description of review standards requirements	Page & paragraph
Hospital/surgical /medical expenses, continued	ORS 743A.080, OAR 836-053-60 Pregnancy and maternity expenses	Coverage includes hospital outpatient and ambulatory services that includes medical supplies used, drugs and medications required to be administered in, and casts applied in a hospital outpatient or ambulatory setting.	
Limits	OAR 836-053-0060 Benefit design	Coverage describes benefit treatment limitation for ongoing medical treatment for confirmed irreversible hepatorenal syndrome, and covers at least 50 percent and not subject to out-of-pocket maximums for the following: 1. Plastic surgery or other cosmetic services required as a result of a non-congenital injury or surgery. 2. Orthognathic or arthroplastic surgery indicated for disorders resulting in impairment of speech, nutrition, or other bodily functions. 3. Focal surgery for epilepsy.	
Major medical expense	ORS 743A.080, OAR 836-053-0060,	Coverage is provided as follows for minimal history and examination, and screening exams for blood pressure, weight and cholesterol levels: 1. Ages 19 years to 39 years, one exam every five years. 2. Ages 40 years to 64 years, one exam every two years.	
Nursing home	OAR 836-053-0060,	Coverage includes 20 days of skilled nursing facility (SNF) care per condition following impatient hospitalization. (*SNF may also be provided under case management for catastrophic injury or illness.*) Policy also covers home health care that includes services of plan providers defined by the carrier for a maximum of 60 consecutive days per condition when significant improvement in function is anticipated and covers home IV therapy following treatment initiated during hospital inpatient treatment.	
Prescription drugs	ORS 743.736, OAR 836-053-0060	Small employer coverage requires a copayment of $15 or 50 percent, whichever is greater, for eligible charges. This benefit is not subject to the stop-loss limit and the carrier may limit coverage to a 30-day supply per prescription.	

Review requirements	Reference	Description of review standards requirements	Page & paragraph
Requirements not part of a listed category	ORS 743.736, OAR 836-053-0060,	Coverage for laboratory procedures, radiology tests, and special diagnostic procedures include EMG, nerve conduction studies, nuclear medicine, pulmonary function, electrophysiology, and medically necessary diagnostic procedures that, at the carrier's option, may require prior approval.	
		Coverage for professional services include home, office, or hospital visits; surgery and anesthesiology; physical, speech, occupational, and respiratory therapy up to 30 visits per condition with a 60-day prenatal care; and medical supplies used in, drug medications required to be administered in, and casts applied in a provider's office.	
		Coverage for transplants includes liver, kidney, heart, lung, or heart/lung; bone marrow for aplastic anemia, leukemia, and lymphoma; severe combined immuno-delivery disease or Wiskott-Aldrich syndrome; corneal; immunosuppressive drugs associated with covered transplant; and pancreas-kidney or pancreas after kidney.	
		Coverage provides for supplemental services including prosthetics (e.g., artificial limbs and eyes or ostomy supplies); durable medical equipment as industry standard requires to include medically necessary and pre-authorization; dialysis (pre-ESRD eligible); and diabetic instructions provided on outpatient basis.	
Small group defined	ORS 743.730(4), ORS 743.733(3)	Defines Oregon small employer group (basic health benefit plan) or HIPAA small employer group and the MEWA contract complies with provisions in OAR 836-053-0021.	
	ORS 743.734(6), OAR 836-053-0021	Different group health plans providing coverage to various categories of employees, as defined by the employer, are applied uniformly to each category of employees.	
	ORS 743.737(7), OAR 836-053-0021 to 0040	Describes contribution and participation requirements.	
Vision	ORS 743.736, OAR 836-053/0060	Coverage is provided for children through age 18 for one general eye examination, including necessary refractions, every 24 months.	

Small Employer Group Rate Requirements			
Review requirements	Reference	Description of review standards requirements	Check answers
Requirement not part of a listed category	ORS 743.737	Each carrier issuing small employer health benefit plans must file its geographic average rates (GARs) for a rating period with the director on or before March 15 of each year.	
		Filing identifies the requested effective date for the proposed rates and the period during which the proposed rates are to be effective.	
		Plans addressed in this rate filing are identified by their approved policy form number and date of approval.	
		Any plans added or withdrawn since the last filing are identified. If none, state so.	
Rate schedules	OAR 836-053-0065	Filing includes full rate tables for the SEHI basic, indemnity, HMO, and PPO as applicable (completed and attached), the geographic average rates as defined in ORS 743.730(16)(a) & (b), and an explanation of how these rates were calculated for all health plans marketed in SEHI.	Yes ☐
		Rates changed since those filed for the previous year, changes (e.g., "rates for all *plans* have increased 5%"), and the reasons for the change are explained in the letter.	Yes ☐
		Provide actual premiums by tiers and areas for the small employer health benefit plan(s) using the following criteria: **Health carriers, service contractors, and indemnity carriers:** **Oregon basic plan:** No deductible/$15 office visit/50% benefit up to $3,750 individual and $7,500 family stop-loss/$15 or 50%, whichever is greater, per prescription/$1,000,000 lifetime max. (*This plan must be offered by all small employer carriers.*) **Indemnity plan:** Deductible $500 individual or $1500 family/80/20% benefit up to $2,000, stop-loss/50% per prescription/$1,000,000 lifetime maximum. **PPO plan:** Deductible $500 individual and $1,500 family/90/70% benefit up to $2,000, stop-loss/50% per prescription/$1,000,000 lifetime max. **MSA-qualified high deductible health plan:** To qualify for self-only coverage, the plan must have an annual deductible not less than $1,700 and not more than $2,500, under which the annual out-of-pocket expenses do not exceed $3,350. (*To qualify for family coverage the plan must have an annual deductible not less than $3,350 and not more than $5,050, under which the annual out-of-pocket expenses do not exceed $6,150.)*	*plans included in filing* Yes ☐ ☐ ☐ ☐

Review requirements	Reference	Description of review standards requirements	Check answers
Rate schedules, continued	OAR 836-053-0065	Provide actual premiums by tiers and areas for the small employer health benefit plan(s) using the following criteria: **Managed-care carriers:** **Oregon basic plan:** No deductible/ $15 office visit/50% benefit/20% total benefits/$3,000 individual and family, $9,000 stop-loss/$15 or 50%, whichever is greater, per prescription. (*This plan must be offered by all small employer carriers.*) **HMO federally-qualified plan:** No deductible/$200 hospital per admission/80% benefit/$1,000 out-of-pocket per individual. Note: Please state if this plan is not federally qualified and identify the differences. **Point of service plan:** Deductible $500/$15 office visit/80% benefit/$1,000 out-of-pocket per individual. **MSA qualified high deductible health plan:** To qualify for self-only coverage, the plan must have an annual deductible not less than $1,700 and not more than $2,500, under which the annual out-of-pocket expenses do not exceed $3,350. (*To qualify for family coverage, the plan must have an annual deductible not less than $3,350 and not more than $5,050, and annual out-of-pocket expenses that do not exceed $6,150.)*	*plans included in filing* Yes ☐ ☐ ☐ ☐
	OAR 836-053-0910	If any change in rate relativities since the last filing, filing includes a description of this change in the accompanying documentation and a complete new demonstration, as required by OAR 836-053-0910, that the new differences between rates for the various plans reflect only differences in benefit provisions. (*A rate change that entails a change in relativities among plans may not be placed into effect until this demonstration is approved.*)	Yes ☐
	ORS 743.737, OAR 836-053-0065	Filing contains a schedule of rates for each plan that includes the following: 1. Proposed effective date of rates. 2. Anticipated period for which this rate schedule will remain in effect. 3. Geographic average rate for each plan for each area by family composition (tiers). 4. Complete table of rates by age and family composition for each plan offered.	Yes ☐ ☐ ☐ ☐
		Future rate changes are: (a) filed to take effect on a contract's anniversary, or (b) are filed to become effective on a fixed date for all individual policies in force. (*If the latter option is chosen, the rate change may only occur once in 12 months and a notice of the schedule for rate changes must be provided with newly issued policies.*)	Check one ☐ (a) ☐ (b)

Review requirements	Reference	Description of review standards requirements	Check answers
Ratemaking, generally	ORS 743.737, OAR 836-053-0065	Filing includes: a. Complete list of premiums or factors for all ages for all other optional benefit plans marketed. If periodic automatic increases are anticipated, a complete list of all such increased premiums. b. Statement of the GAR for each plan and area. c. Table of all relativity benefit factors by plan. d. Table of all area factors. e. Written explanation to any factor changes from prior approved rate filing is included in this filing.	Yes ☐ ☐ ☐ ☐ ☐
		A complete explanation is given for major differences between the last filed small group rate adjustment and this rate adjustment.	Yes ☐
	ORS 743.737, OAR 836-053-0065	**Method used to compute rate change** *(must be based on carrier's own data)* **Note:** Premium and claim information below may be expressed as per member per month (pmpm), if desired. a. Experience period for earned premiums and claims. b. Dollar amount of earned premiums for experience period. (*In accompanying documentation, show actual experience premiums, if different, and explain method by which such premiums were adjusted so that all premiums in the experience period were consistent with current premiums prior to proposed rate changes.*) c. Dollar amount of incurred claims for experience period. (*In accompanying documentation, show actual paid claims and explain method by which incurred claims were determined from paid claims.*) d. Incurred claims loss ratio equals: c / b e. Dollar amount of trended claims. (*In accompanying documentation, provide annual trend factor, as well as relevant information as to source of such factor.*) f. Dollar amount of trended claims adjusted by benefit or area, if different. (*In accompanying documentation, provide explanation as to need for adjustment and how adjustment factors were determined.*) g. Dollar amount of sum of trended claims, administration costs, and contingency margins. (*In accompanying documentation, explain whether costs are expressed as percentage of final premium, as flat dollar amount per unit, or both. The administrative costs should be stated separately from contingency margins.*) h. Loss ratio with administration equals: g / b i. Required loss ratio with administration. (*Explain any variation from 100%.*) j. Required premium: (h / i) x b k. Required percentage change in premium: (j – b) / b x 100	Yes ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐