Department of Consumer and Business Services
Oregon Division of Financial Regulation - 5
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Standard Provisions for Dental and Vision Forms

Use this product standard when filing vision or dental forms (other than exchange certified pediatric dental) or when a dental or vision rider is added to a base policy.

For exchange certified pediatric dental product standards, use *Standard Provisions for Exchange Certified Pediatric Dental (ACA compliant) Forms* (Form 440-4978) instead.

This product standard checklist must be submitted with your filing, in compliance with OAR 836-010-0011(2). This list includes national standards, relevant statutes, rules, and other documented positions to enforce ORS 731.016. The standards are summaries and review of the entire statute or rule will be necessary. Complete each item to confirm that diligent consideration has been given to each and is certified by the signature on the Certificate of Compliance form. "Not applicable" can be used only if the item does not apply to the coverage being filed. 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: _____ **Requested effective date:** _____

TOI (type of insurance): ☐ H10I Individual Health - Dental ☐ H10G Group Health - Dental

☐ H20I Individual Health - Vision ☐ H20G Group Health - Vision

Marketing: ☐ Small group ☐ Large group ☐ Stand alone

Base policy: ☐ Health benefit plan ☐ Health insurance policy

*" * " Does not apply to Health Care Service Contractors per ORS 750.055.*

GENERAL REQUIREMENTS (FOR ALL FILINGS)			
Review requirements	Reference	Description of review standards requirements	Answer
Submission package requirements	OAR 836-010-0011 As required on SERFF or our website	Required forms are located on SERFF or on our website: http://dfr.oregon.gov/rates-forms/health/Pages/health.aspx. These must be submitted for your filing to be considered 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 persons. 5. Readability certification. 6. Product standards for forms (this document). 7. Actuarial memorandum with an overview of the contents of the filing and the reasons and procedures used to derive the rates (individual only). 8. Forms filed for approval. (If filing revised forms, include a ***highlighted*** copy of the revised form to identify the modification, revision, or replacement language.) 9. For mailed filings, submit two sets of the complete filing and one self addressed stamped envelope large enough to return the approved forms. 10. Statement of Variability (see "Variability in forms" section).	Yes N/A ☐
	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 similar forms. 2. Summary of the differences between previously-approved or 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	The following are submitted in this filing for review: 1. New policy and certificate, if applicable. 2. Changes to a previously-approved form. 3. Endorsements or riders.	Yes N/A ☐ ☐ ☐ ☐ ☐ ☐
GENERAL FORM REQUIREMENTS (FOR ALL FILINGS)			
Review requirements	Reference	Description of review standards requirements	Answer
Clarity and readability	ORS 742.005(2) Clear and understandable forms	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 ☐

Review requirements	Reference	Description of review standards requirements	Answer
Cover page	ORS 742.023*, ORS 743.405(7)* (individual), OAR 836-010-0011 (all)	1. The full corporate name of the insuring company appears prominently on the first page of the policy. 2. A marketing name or insurer logo, if used on the policy, does not mislead as to the identity of the insuring company. 3. The insuring company's address, consisting of at least a city and state, appears on the first page of the policy. 4. The signature of at least one company officer appears on the first page of the policy. 5. The individual policy or 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 others used by the insurer. 7. The policy contains a brief caption that appears prominently on the cover page and describes the type of coverage.	Yes ☐ N/A ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
Form numbers	ORS 743.405(7)* (individual), OAR 836-010-0011 (all)	The policy and certificate are filed under one form number and that form provides core coverage with all basic requirements. Basic policy requirements are not bracketed unless an alternative selection is included. Additional optional benefits to the policyholder are filed under separate form numbers.	Yes ☐ N/A ☐
Groups separated	OAR 836-010-0011 (group only)	File small group and large group filings in separate filings. Use the appropriate TOI and Sub-TOI for the group size being submitted in this filing.	Yes ☐ N/A ☐
Table of contents	ORS 743.103, ORS 743.106(1)(d)	Policy and certificate contain a table of contents or index of the principal sections if longer than 3 pages or 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. <u>For example:</u> [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 ☐

Review requirements	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. DRAFTER'S NOTES: Drafter's notes are embedded into the form and provide full explanation for all variable text and data. Drafter's notes should be highlighted, shaded, or in a different text color; embedded in the form; and placed either directly before or after the variable text. 2. STATEMENT OF VARIABILITY (SOV): 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 ☐

APPLICABILITY

Review requirements	Reference	Description of review standards requirements	Answer
Advertisements	ORS 742.009, OAR 836-010-0011, OAR 836-020-0200 to 305, Form 440-3308H	If filing a new dental or vision product, Form 440-3308H (*Standards for Health Advertisements*) is or will be filed prior to issuance. Sales materials for insurance products shall not be false, deceptive, or misleading.	Yes ☐ N/A ☐
Applications	Form 440-2442H	If an application is submitted in the filing, also complete and submit *Standards for Health Applications* (Form 440-2442H).	Yes ☐ N/A ☐

Review requirements	Reference	Description of review standards requirements	Answer
Associations, trusts, or discretionary groups	ORS 731.486*, ORS 743.522, ORS 743.524 (group)	If filing includes group plans through Associations, Trusts, Union Trusts, or Discretionary groups, carrier must file the group's qualifications and applicable documents contained in Form 440-2441A before any coverage is issued.	Yes ☐ N/A ☐
Assumption certificates	Form 440-3637	File under *Changes to Business Operations that Require a Filing* (Form 440-3637).	
Exchange certified pediatric dental	Form 440-4978	For exchange certified pediatric dental product standards, use Standard Provisions for Exchange Certified Pediatric Dental (ACA compliant) Forms (Form 440-4978) instead.	
Health benefit plans	ORS 743.730(18)(a)*	Coverages that are not exclusive to a condition, disease, or service and are not listed as an exclusion under ORS 743.730(18)(b) are health benefit plans. (See product standards for health benefit plans for filing those coverages.)	
Health Care Service Contractor (HCSC)	ORS 750.055 Health Care Service Contractor (HCSC)	Statute references followed by an asterisk (*), may be marked "N/A" in the location column if filed for a HCSC. These standards do not apply to HCSCs per ORS 750.055.	
POLICY PROVISIONS			Page and paragraph
Review requirements	Reference	Description of review standards requirements	Answer
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 this state if agreed upon.	N/A ☐
Cancellation and nonrenewal	ORS 743.495, ORS 743.498 (individual)	A non-cancelable or guaranteed-renewable policy includes the statement required by ORS 743.498 or similar language explaining the guaranteed or cancelable periods.	N/A ☐
Claim forms	ORS 743.426* (individual), ORS 743.028, OAR 836-080-0225(4)	The "claim forms" statement in ORS 743.426 or a similar statement is included in the policy, providing that if claim forms are required and are not furnished within 15 days after the claimant gives notice of claim, the claimant shall be deemed to have complied with the requirement of the policy.	

Review requirements	Reference	Description of review standards requirements	Answer
Claim notice	ORS 743.423(1)* (individual), OAR 836-080-0210(6)	The "notice of claim" statement in ORS 743.423(1), or a similar statement, is included in the policy, explaining that written notice of claim is given to the insurer within 20 days after occurrence or commencement of any loss covered by the policy or as soon thereafter as is reasonably possible.	
Claim payment	ORS 743.432* (individual), OAR 836-080-0220, OAR 836-080-0225(1)	A "time payment of claims" statement similar to that in ORS 743.432 is included in the policy, stating that indemnities payable will be paid immediately upon receipt of due written proof of loss or stating the intervals of periodic payment of benefits.	N/A ☐
	ORS 743.531* (group)	A group health insurance policy may, on request by the group policyholder, provide that all or any portion of any indemnities provided by such policy on account of hospital, nursing, medical or surgical services may, at the insurer's option, be paid directly to the hospital or person rendering such services.	N/A ☐
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 -0796.	N/A ☐
		Reduction of benefit payments on the basis of other insurance for the insured individual is in full accordance with coordination-of-benefits rules.	N/A ☐
Definition of class	ORS 742.005(6), ORS 743.018	If the insurer uses class for the purpose of rating, the policy includes a definition of class that is consistent with the actuarial basis.	
Dependent coverage	ORS 743.847(6) 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.	Confirmed ☐
	ORS 106.300 to 340, Bulletin 2008-2 Domestic partners	The Oregon Family Fairness Act (ORS 106.300 to 106.340) recognizes and authorizes domestic partnerships in Oregon. An Oregon registered 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.	
	OAR 105-010-0018 Same-sex marriages performed in other states	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 in other states now qualify as spouses under COBRA and state continuation.	Confirmed ☐

Review requirements	Reference	Description of review standards requirements	Answer
Discretionary clauses	ORS 742.005(2)(3)(4)	If a 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).	Confirmed ☐ N/A ☐
Discrimination	ORS 746.015	No person shall make or permit any unfair discrimination between individuals of the same class and equal expectation of life, or between risks of essentially the same degree of hazard, 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 ☐
	ORS 743A.084 Unmarried women and their children	The policy does not discriminate between married and unmarried women or between children of married and unmarried women.	Confirmed ☐
	ORS 746.015(2) Physical disability	This contract does not discriminate in its underwriting standards and or rates solely on an individual's physical disability.	Confirmed ☐
	ORS 746.015(3) Age 65	This contract complies with ORS 746.015(3) by not discriminating against a person who attains or exceeds age 65, unless such discrimination is based on clear and sound actuarial principals as well as anticipated experience.	Confirmed ☐
	ORS 746.015(4) Domestic violence	This contract complies with ORS 746.015(4) by not cancelling, refusing to issue, or renew this policy on the basis of the fact that an insured or prospective insured is or has been a victim of domestic violence.	Confirmed ☐
Eligibility for benefits	ORS 743.847(2)	Eligibility for benefits is not determined based on eligibility for Medicaid.	Confirmed ☐
Emergency definition	ORS 742.005	If the contract or base policy offers dental or vision emergency services, an "emergency" definition must be included.	N/A ☐
Entire contract	ORS 742.016* (all), ORS 743.411* (individual)	The "entire contract" statement in ORS 743.411 or similar statement is included in the policy, explaining that the contract, including the endorsements and attached papers, if any, constitutes the entire contract of insurance.	
Examination of contract	ORS 743.492 (individual)	There is a provision printed on the face of the policy or attached thereto entitling the prospective insured to a 10-day period in which to examine and return the policy for a refund of any premium paid, including any policy fees or other charges. If returned, the policy is considered void from the beginning and the parties are in the same position as if no policy had been issued.	N/A ☐

Review requirements	Reference	Description of review standards requirements	Answer
Fraud statements	ORS 742.013, Bulletin 2010-03	If a fraud statement is included in the contract, it should be within the guidelines delineated in Bulletin 2010-03. The statement must be general in nature, using "may be" guilty of fraud and "may be" subject to civil or criminal penalties if intentional and material to the risk.	N/A ☐
Grace period	ORS 743.417* (individual), ORS 743.560 (group)	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.	
Incontestability	ORS 743.414(3),(4)* (individual)	The "incontestable" statement in ORS 743.414(3) and (4) or a similar statement is included that states after two years from the date of issue of this policy, no misstatements except fraudulent misstatements made by the applicant shall be used to void the policy or to deny a claim and losses after two years are covered.	N/A ☐
Inducements not specified in policy	ORS 746.035	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.	N/A ☐
Injuries resulting from alcohol and controlled substances	ORS 743A.164 (individual)	A health insurance policy shall provide coverage or reimbursement of expenses for the medical treatment of injuries or illnesses caused in whole or in part by the insured's use of alcohol or a controlled substance to the same extent as and subject to limitations no more restrictive than those imposed on coverage or reimbursement of expenses arising from treatment of injuries or illnesses not caused by an insured's use of alcohol or a controlled substance.	N/A ☐
Legal action	ORS 743.441* (individual)	Provision states that no action at law or in equity is brought to recover on this policy prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the policy. No action shall be brought after the expiration of 3 years after the time written proof of loss is required.	N/A ☐
Physical examination and autopsy	ORS 743.438* (individual)	The "physical examinations and autopsy" statement in ORS 743.438 or a similar statement is included in the policy, explaining that the insurer at its own expense shall have the right and opportunity to examine the insured when and as often as it may reasonably require while a claim is pending.	N/A ☐
Proof of loss	ORS 743.429* (individual)	The "proof of loss" statement in ORS 743.429 or a similar statement that proof of loss is due to the insurer within 90 days of the loss or, in the case of continuing loss for which the insurer is obligated to make periodic payments, 90 days after the end of the period of insurer liability. (*If it is not reasonably possible for the policyholder to meet this requirement, the claim shall not be invalidated or reduced if proof of loss is provided as soon as is reasonably possible and not later than one year after the date proof is otherwise required, except in the absence of legal capacity*.)	N/A ☐
	OAR 836-080-0230, OAR 836-080-0235, ORS 746.230	If the policy includes claim procedures, the procedures and timelines comply with fair claim practice requirements.	

Review requirements	Reference	Description of review standards requirements	Answer
Provider reimbursement	ORS 743A.032* Dentist	Coverage provides reimbursement for surgical services that is within the lawful scope of practice of a licensed dentist, if policy provided benefits when a physician performed the service.	N/A ☐
	ORS 743A.028* Denturist	Policies for dental health that provide reimbursement for services of a denturist reimburse for the same services, if performed by a licensed dentist.	N/A ☐
	ORS 743A.034 Expanded practice dental hygienist	If a policy covering dental health provides for coverage for services performed by a dentist, the policy must also cover the services when they are performed by an expanded practice dental hygienist, as defined in ORS 679.010.	N/A ☐
	ORS 743A.036 Nurse practitioner or physician assistant	Coverage provides reimbursement for any service that is within the lawful scope of practice of a duly licensed and certified nurse practitioner or licensed physician assistant, if the policy provided benefits when a physician performed the service.	N/A ☐
	ORS 743A.040*, ORS 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.	N/A ☐
	ORS 743A.044* Physician assistant	An insurer may not refuse a claim solely on the ground that the claim was submitted by a physician assistant, rather than by the supervising physician.	N/A ☐
	ORS 743A.010 State hospital or state approved program	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 ☐
Rebate prohibition	ORS 746.045	No person shall personally or otherwise offer, promise, allow, give, set off, pay or receive, directly or indirectly, any rebate of or rebate of part of the premium payable on an insurance policy 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.	N/A ☐
Reinstatement	ORS 743.420* (individual)	A provision states that if the renewal premium has not been paid within the time granted but an insurer or authorized agent subsequently accepts a premium the policy shall be reinstated. The only exception is an application for reinstatement required to be submitted by the enrollee and accepted by the insurer.	N/A ☐

Review requirements	Reference	Description of review standards requirements	Answer
Time limit on certain defenses	ORS 743.414(1)* (individual)	A provision states that after two years from the date of issue of the policy no misstatements, except fraudulent misstatements, made by the applicant shall be used to void the policy or to deny a claim.	N/A ☐
	ORS 743.414(2)* (individual)	The policy provision above shall not be so construed as to affect any legal requirement for avoidance of a policy or denial of a claim during such initial two-year period, or to limit the application of ORS 743.450 to 743.462 in the event of misstatement with respect to age or occupation or other insurance.	N/A ☐
Usual, customary, or reasonable, defined	ORS 742.005	Filing includes a definition for "usual, customary, and reasonable" (UCR) that fully discloses how UCR benefits are determined. (*If a national database or alternate method is used, it must be described, including any percentile applied*. *Bracketing or variables are not permitted within this definition.)*	
RATE REQUIREMENTS (INDIVIDUAL ONLY)			
Review requirements	Reference	Description of review standards requirements	Answer
Filing request	OAR 836-010-0011	The following review is requested: 1. New rate filing. 2. Rate change.	Requested ☐ ☐
Combined classes	ORS 742.041*	This filing includes classes of combined life and health insurance. (No other classes are combined in this filing in which the liability of the insurer for unearned premiums or the reserve for unpaid, deferred, or undetermined loss claims is estimated in a different manner.)	Yes ☐ No ☐
Loss ratios	OAR 836-010-0021(1)	**Rate changes.** Successive generic policy forms of similar benefits covering generations of policyholders must be combined in the calculation of premium rates and loss ratios.	Yes ☐
Premium changes	ORS 742.005, ORS 743.018	Premium changes are subject to prior approval and should not be filed more than once in a 12-month period.	Confirmed ☐
Ratemaking	OAR 836-010-0011	Appendix A (Form 440-2462) is included and all columns completed showing support of the rate change requested; it includes actual and projected experience and overall loss ratio from policy inception for Oregon and the company's national experience.	Yes ☐
		A complete actuarial memorandum, signed by an accredited actuary, is included containing a description of all policy benefits and the actuarial assumptions used to develop each of the benefits. (*Include a description of the risk and the assumptions used in developing the cost.*)	Yes ☐
		The expected experience of the new rate or existing rate for the projected calculating period over which the actuary expects the premium rates to remain adequate is based on estimated future experience without expected rate increases.	Yes ☐

Review requirements	Reference	Description of review standards requirements	Answer
Ratemaking, continued	OAR 836-010-0011	The source of the data; information about new or experimental benefits; and explanation of the reliability of projections, abrupt changes in the experience, and substantial differences between actual and expected experience are included.	Yes ☐
		A statement that the grouping of policy forms has not changed or an explanation of the changes is included. Experience of forms must be grouped according to similar types of benefits, claims experience, reserves, margins for contingencies, expenses and profit, renewability, underwriting, and equity between policyholders.	Yes ☐
		The premium structure, as defined by the classification of insureds in the policy, is not changed at the time of rate increase (e.g., changes from issue-age to attained-age basis).	Yes ☐
	ORS 733.030	Filing identifies how reserving assumptions (including specific company experience) take into account any expected adverse mortality and lapses that are reflected in the pricing.	Yes ☐
Renewability	ORS 742.023*, ORS 743.018	A premium change or renewability provision provides for premium changes only when such changes apply to all policies of this form, are issued to persons in the same class in this state, and have been approved by the Oregon Division of Financial Regulation.	Yes ☐ No ☐
Underwriting	ORS 731.296	Mark the type of health underwriting filed for the forms included in this rate request: 1. Full underwriting. 2. Simplified underwriting. 3. No underwriting	Mark one ☐ ☐ ☐