

Department of Consumer & Business Services

**Oregon Insurance Division – 5**

P.O. Box 14480  
350 Winter St. NE  
Salem, Oregon 97309  
Phone (503) 947-7983

**Standard Provisions for Small Employer Health Benefit Plans**

**Pursuant to ORS 743.736, 743.737 and OAR 836-053-0060**

NOTE: HOUSE BILL 2002 INCREASED THE SMALL EMPLOYER GROUP SIZE TO 50 EMPLOYEES EFFECTIVE 1-1-08

This 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 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.)*

An outline of the Small Employer Basic Indemnity or Health Benefit Plan referenced in OAR 836-053-0060 including benefits, limits, and cost-sharing requirements can be found at <http://www.cbs.state.or.us/external/ins/forms/consumer/3313.pdf> (form 440-3313).

**TOI (type of insurance):**  H16G Group health - Major medical  
 H15G.003 Group Health – Hospital/Surgical/Medical Expense

**Sub-TOI:**

- 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, EPO, etc)
- H15G.003 Small group only

**Type of group:**  Oregon small employer, ORS 743.730 (as amended by HB 2002)

**Type of coverage:**  Indemnity  Health Care Service Contractor  
*(\*Indicates standard does not apply per ORS 750.055)*

- Basic Small Employer Plan (mandatory)
- Additional Small Employer Plan (optional)

## GENERAL REQUIREMENTS (FOR ALL FILINGS)

Category	Reference	Description of review standards requirements	Answer Y or N/A	
Submission package requirements	OAR 836-010-0011 As required on SERFF or our Web site	Required forms are located on SERFF or on our Web site: <a href="http://www.oregoninsurance.org/docs/serff/filing_requirements.htm">www.oregoninsurance.org/docs/serff/filing_requirements.htm</a> . These must be submitted with your filing for your filing to be accepted as complete: <ol style="list-style-type: none"> <li>1. NAIC transmittal form (paper filings only).</li> <li>2. Filing description in SERFF or on transmittal form (cover letter).</li> <li>3. Third party filer's letter of authorization.</li> <li>4. Certificate of compliance form signed by authorized person.</li> <li>5. Readability certification.</li> <li>6. Product standards for forms (this document).</li> <li>7. Actuarial memorandum with an overview of the contents of the filing and the reasons and procedures used to derive the rates (see requirements for rates).</li> <li>8. Forms filed for approval. (If filing revised forms, include a <b>highlighted</b> copy of the revised form to identify the modification, revision, or replacement language.)</li> <li>9. For mailed filings, two self-addressed stamped envelopes, one in which the Insurance Division can return approved forms.</li> </ol>	Yes <input type="checkbox"/>	N/A <input type="checkbox"/>
Form submission package requirements	Filing description	The filing description (cover letter) includes the following: <ol style="list-style-type: none"> <li>1. Changes made to prior approved plan or variations from other approved plans.</li> <li>2. All like approved forms for a like product and a summary of the differences between the approved like form and the new form.</li> <li>3. The differences between in-network and out-of-network.</li> </ol>	Yes <input type="checkbox"/>	N/A <input type="checkbox"/>
Rates	Form 440-4872	If filing rates, Product Standards 440-4872 are included in the filing?	Yes <input type="checkbox"/>	N/A <input type="checkbox"/>
Review requested	ORS 742.003(1), OAR 836-010-0011(3), ORS 743.761, ORS 743.405(7)	The following are submitted in this filing for review: <ol style="list-style-type: none"> <li>1. New policy and/or certificate.</li> <li>2. Amendment of an approved form.</li> <li>3. Forms are identified with unique form numbers and revision dates in the lower left-hand corner of each page of each form.</li> <li>4. Endorsements for waivers.</li> </ol>	Yes <input type="checkbox"/>	N/A <input type="checkbox"/>
Multiple Employer Welfare Arrangement	ORS 750.301 to 341	File under checklist of standards for <b><u>Standard Provisions for Multiple Employer Welfare Arrangements Group Health Benefit Plans,</u></b> Form 440-2448m.		
Associations/trusts/discretionary groups	ORS 731.486, ORS 743.522, ORS 743.524, ORS 743.526	Transmittal and standards for qualifying an association, trust, or discretionary group, Form 440-2441A or 440-2441D are included.	Yes <input type="checkbox"/>	N/A <input type="checkbox"/>

Category	Reference	Description of review standards requirements	Answer Y or N/A
Assumption certificates	Form 440-3637	File under checklist of standards for <u>Changes to Business Operations that Require a Filing</u> , Form 440-3637.	
Applicability	Health care service contractors (HCSC)	(Statute references followed by an asterisk (*), may be marked "N/A" in the location column. These standards do not apply to HCSC per ORS 750.055.)	
	ORS 743.730(19)(b)	Health benefit plan does not include coverages listed in ORS 743.730(19)(b). (See the appropriate checklist for filing those coverages.)	Yes <input type="checkbox"/>
	45 CFR, Part 160 & Subparts A & E of 164	Policy meets all HIPAA privacy requirements and all HIPAA-related statements are solely supported by HIPAA requirements.	Yes <input type="checkbox"/>
	ORS 743A.012	Health benefit plans are required to provide information to enrollees regarding coverage for emergency services and appropriate use of 9-1-1.	Yes <input type="checkbox"/>
	OAR 836-053-0001	Submit transmittal and requirements for <u>Modification and Discontinuance of Health Benefit Plans</u> , Form 440-2896, when eliminating or adding benefits, decreasing or increasing benefits payable or deductibles and copayments, or establishing new conditions or requirements.	
Application	OAR 836-053-0510	No application with medical questions is used to enlist new enrollees and only the Oregon Health Statement (Exhibit 1 of OAR 836-053-0510) is used for late enrollees.	Yes N/A <input type="checkbox"/> <input type="checkbox"/>
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.	Yes N/A <input type="checkbox"/> <input type="checkbox"/>
	ORS 743.106(1)(d), ORS 743.103	Policy and certificate contains a table of content or index of the principal sections if longer than three pages or 3,000 words.	Yes N/A <input type="checkbox"/> <input type="checkbox"/>
Form number	ORS 743.405(7)	The policy is 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. Other forms are identified with their unique form number and edition date. (See guidelines on our Web site: <a href="http://www.oregoninsurance.org/docs/healthun/health6.htm">www.oregoninsurance.org/docs/healthun/health6.htm</a> .)	Yes N/A <input type="checkbox"/> <input type="checkbox"/>
Variable text	ORS 742.005(2), ORS 742.003	Variable data is indicated by brackets and all variable ranges or options are identified. The filing includes a statement of variability that explains the conditions under which each variable item may change. A statement of variability presents reasonable and realistic ranges for each item. The filing also includes 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. Variable data may be included within the coverage form or may be submitted as a separate form identified by its own form number and date.	Yes N/A <input type="checkbox"/> <input type="checkbox"/>

## GENERAL FORM REQUIREMENTS

Category	Reference	Description of review standards requirements	Answer Y or N/A	
Cover page	National standards ORS 742.005	1. The full corporate name of the insuring company appears prominently on the first page of the policy.	Yes <input type="checkbox"/>	N/A <input type="checkbox"/>
		2. A marketing name or insurer's logo, if used on the policy, must not mislead as to the identity of the insuring company.	<input type="checkbox"/>	<input type="checkbox"/>
	ORS 743.492	3. The insuring company address, consisting of at least a city and state, appears on the first page of the policy.	<input type="checkbox"/>	<input type="checkbox"/>
		4. The signature of at least one company officer appears on the first page of the policy.	<input type="checkbox"/>	<input type="checkbox"/>
	ORS 743.405(7)	5. The individual certificate includes a right-to-examine provision that appears on the cover page of the certificate.	<input type="checkbox"/>	<input type="checkbox"/>
		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. ORS 743.405(7)	<input type="checkbox"/>	<input type="checkbox"/>
	ORS 743.106(1)(d)	7. The policy contains a brief caption that appears prominently on the cover page and describes the type of coverage.	<input type="checkbox"/>	<input type="checkbox"/>
		8. The policy includes a table of contents that easily identifies where to locate the provisions. ORS 743.106(1)(d)	<input type="checkbox"/>	<input type="checkbox"/>

## POLICY PROVISIONS

			Page & Paragraph or	
Category	Reference	Description of review standards requirements	Check Y or N/A	
Ambulance	ORS 743.014*	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.164	Does not include exclusion for claims arising from use of alcohol or controlled substance. Coverage must be to the same extent as coverage for other injuries or illnesses.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
	ORS 743A.168, OAR 836-053-1404, OAR 836-053-1405, Bulletin 2003-3	All plans include coverage for mental or nervous conditions and chemical dependency, including alcoholism. Coverage must be as broad and no more restrictive than coverage for other medical conditions.		
	ORS 743A.190	Provides benefits for medically necessary treatment of pervasive developmental disorders for children under age 18.		
	ORS 743A.110	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. Include the definition of mastectomy in the contract.		

Category	Reference	Description of review standards requirements	Page & paragraph
Benefit reimbursement, continued	ORS 743A.080	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.184	Diabetes: Coverage provides reimbursement for supplies, equipment, and diabetes self-management programs.	
	ORS 743A.010	Policy does not exclude benefits for covered services because they were provided by any hospital owned or operated by the State of Oregon, or any state approved community mental health and developmental disabilities program.	
	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.	
	ORS 743A.148	Coverage includes maxillofacial prosthetic services necessary for adjunctive treatment.	
	OAR 836-052-1000	Prosthetic and orthotic coverage is based on Medicare's fee schedule for DME.	
	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 provides benefits when a physician performs the service.	
	Senate Bill 860	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.	
	ORS 743A.058	Coverage for telemedical services via two-way video communication. Coverage of telemedical health services such as hospital, rural health clinic, doctor's office, community mental health, etc. Coverage equal to contract covered services Effective 1/1/2010.	
	Senate Bill 787	Coverage for telemedical services via two-way electronic communication, that allows health professionals to interact with a patient, a parent or guardian of a patient in connection with the treatment of with diabetes.	
	ORS 743A.036	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.024*	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 provides benefits when a physician or psychologist performs the service.	

Category	Reference	Description of review standards requirements	Page & paragraph
Benefit reimbursement, continued	ORS 743A.032*	Coverage provides reimbursement for any surgical service that is within the lawful scope of practice of a licensed dentist, if policy provides benefits when a physician performs the service.	
	ORS 743A.044*	Claims submitted directly by physician assistants, are to be paid as if submitted by the supervising physician.	
	ORS 743A.188	Coverage includes treatment of inborn errors of metabolism that involve amino acids, carbohydrates, and fat metabolism.	
	ORS 743A.100	Coverage provides for mammogram reimbursement for the purpose of early detection in symptomatic or high risk woman anytime recommended by the health care provider, and annually for women 40 years of age and older.	
	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.	
	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 743A.108*	Coverage includes clinical breast examinations.	
	ORS 743A.120*	Coverage includes prostate cancer screening examinations.	
	ORS 743A.020	Acupuncture: Covered services when performed by a physician must also be covered when performed by a licensed acupuncturist.	
	ORS 743A.124*	Coverage includes colorectal cancer screening examinations and lab tests.	
	ORS 743A.068	Plans that provide coverage for cancer chemotherapy treatment must extend coverage for a prescribed, orally administered anticancer medication.	
	Oregon Laws 2007, Ch. 484	Plans must extend filing of claim deadline, for claims filed by Medicaid, to three years.	
	ORS 743A.140	Cochlear implants: Plans providing coverage must extend to include bilateral services.	
	ORS 743A.144	Benefits include coverage for prosthetic and orthotic devices.	
ORS 743A.066	If the plan includes a prescription program the plans provides coverage for oral contraceptives and related services.		
ORS 743A.190	For children under the age of 18, the policy includes pervasive developmental disorder benefits at the same level as other conditions.		

Category	Reference	Description of review standards requirements	Page & paragraph
Cancellation and nonrenewal	ORS 743.560, ORS 743.565, OAR 836-052-0800 to 0860	Required minimum grace period and notice of termination requirements.	
	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.	
Grievance and appeals	Senate Bill 89	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.	
	ORS 743.801(1)(a-e) ORS 743.801(2) ORS 743.801(8) OAR 836-053-1030	<p>Include the statutory definition of:</p> <p><b>A. Adverse Benefit Determination:</b></p> <ul style="list-style-type: none"> <li>• Denial of eligibility for or termination of enrollment in a health benefit plan;</li> <li>• Rescission or cancellation of a policy or certificate;</li> <li>• Imposition of a preexisting condition exclusion as defined in ORS 743.730, source-of injury exclusion, network exclusion, annual benefit limit or other limitation on otherwise covered items or services;</li> <li>• Determination that a health care item or service is experimental, investigational or not medically necessary, effective or appropriate; or</li> <li>• 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.,</li> </ul> <p><b>B. Authorized Representative:</b> An individual who by law or by the consent of a person may act on behalf of the person.</p> <p><b>C. Grievance:</b> A request submitted by an enrollee or an authorized representative of an enrollee:</p> <ul style="list-style-type: none"> <li>• 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</li> <li>• A written complaint submitted by an enrollee or an authorized representative of an enrollee regarding the: <ul style="list-style-type: none"> <li>○ Availability, delivery or quality of a health care service;</li> <li>○ 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</li> <li>○ Matters pertaining to the contractual relationship between an enrollee and an insurer</li> </ul> </li> </ul>	

Category	Reference	Description of review standards requirements	Page & paragraph
Grievance and appeals, continued	ORS743.804(1)(a)(C)(D), ORS 743.804(1)(b)(A)(B)(C)(D), ORS 743.804(2)(a)(c-e)(A-B), OAR 836-053-1030, OAR 836-053-1100	<p><b>Internal Appeals</b></p> <p><u>The following must be disclosed:</u></p> <ul style="list-style-type: none"> <li>• Receipt of an initial grievance or the first or second appeal will be acknowledged in writing within seven days.</li> <li>• The insurer must make a decision on the grievance or internal appeal within 30 days but may take an additional 15 days if they provide notice of delay within the first 30 days.</li> <li>• The insurer will expedite internal appeal(s) when required by clinical urgency and provide a clear explanation of the procedure for requesting expedited review.</li> <li>• 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.</li> <li>• When an insurer provides one level of internal appeal, a person involved in the initial denial may not be involved in the internal appeal.</li> <li>• An enrollee may authorize a representative to act on the enrollee's behalf during the appeal.</li> <li>• 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.</li> <li>• An enrollee may receive, free of charge, reasonable access to documents used in the adverse benefit determination.</li> <li>• For adverse benefit determinations that qualify for external review, the insurer can waive its internal appeals process and move straight to external review.</li> <li>• An enrollee has the right to file a complaint with or seek assistance from the Department of the Consumer and Business Services. Contact information, including the phone number and address for the division, must also be included.</li> <li>• That the enrollee is entitled to receive continued coverage of the disputed item or service pending the conclusion of the appeal and review process, but that if the insurer's denial is not reversed, that the enrollee will be responsible to pay for the disputed item or service.</li> </ul>	
	ORS 743.804(2)(g)	The enrollee must be allowed to receive continued coverage pending the conclusion of the internal appeal process.	

Category	Reference	Description of review standards requirements	Page & paragraph
Grievance and appeals, continued	ORS 743.857, ORS 743.859, ORS 743.861, OAR 836-053-1030, OAR 836-053-1342, OAR 836-053-1325, OAR 836-053-1340	<p><b>External Review</b></p> <p>The insurer must have a process in place for an external review with an Independent Review Organization (IRO) chosen by the director. The insurer must provide an explanation of when external review is available and how to request external review. In addition the following must be disclosed:</p> <ul style="list-style-type: none"> <li>• 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.</li> <li>• An IRO must complete their review within: <ul style="list-style-type: none"> <li>○ 3 days for expedited reviews (notification is immediate)</li> <li>○ 30 days when not expedited (notification with within 5 days)</li> </ul> </li> <li>• 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: <ul style="list-style-type: none"> <li>○ medically necessary</li> <li>○ experimental or investigational</li> <li>○ an active course of treatment for purposes of continuity of care under ORS 743.854.</li> <li>○ delivered in an appropriate health care setting and with the appropriate level of care.</li> </ul> </li> <li>• The insurer shall pay the cost of the external review.</li> <li>• When an enrollee requests external review, the enrollee must authorize release of medical records needed by the IRO.</li> <li>• The enrollee may submit additional information to the independent review organization no later than 5 business days after the appointment of the IRO or 24 hours in the case of an expedited review..</li> <li>• 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.</li> <li>• A description of the circumstances in which the enrollee can move to external review and bypass internal appeals.</li> <li>• The following in boldface type or otherwise emphasized: <ul style="list-style-type: none"> <li>○ The enrollee has the right to external review.</li> <li>○ The insurer is bound to follow the decision of the IRO, and may be penalized by DCBS if it fails to do so.</li> <li>○ The enrollee has the right to sue the insurer if the decision of the IRO is not implemented.</li> </ul> </li> </ul>	

Category	Reference	Description of review standards requirements	Page & paragraph
Grievance and appeals, continued	ORS 743.804(5); OAR 836-053-1030(12)	Insurers must disclose that the following additional information is available upon request: <ul style="list-style-type: none"> <li>• Annual summary of grievance and appeals;</li> <li>• An annual summary of utilization review policies;</li> <li>• An annual summary of quality assessment activities;</li> <li>• The results of all publically available accreditations surveys;</li> <li>• An annual summary of the insurer's health promotion and disease prevention activities;</li> <li>• An annual summary of scope of network and accessibility of services.</li> </ul>	
Continuation of coverage	ORS 743.527(1)(a)	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 immediately replaced by another insurance carrier.	
	ORS 743.529(2), OAR 836-082-0050 to 0055	Provides uninterrupted coverage when the existing policy is replaced.	
	ORS 743.530*	Provides for continuation of coverage after injury or illness claim filed for workers' compensation.	
	ORS 743.600, ORS 743.601, ORS 743.602	Provides continuation of coverage for surviving, divorced, or separated spouse 55 or older for employers with 20 or more employees.	
	ORS 743.610, OAR 836-053-0851, OAR 836-053-0859, OAR 836-053-0861, OAR 836-053-0866	Policy describes continuation of coverage requirement for employers with less than 20 employees.	
	ORS 743.760(1)(12), OAR 836-053-0750	Includes state and federal eligibility requirements to obtain an individual portability plan.	
Coordination of benefits	ORS 743.549, ORS 743.552, OAR 836-020-0770 to 0806	If policy applies coordination of benefits, it complies with ORS 743.549, ORS 743.552, and OAR 836-020-0770 to 0806.	
		Reduction of benefit payments on the basis of other insurance for the insured individual is in full accordance with coordination-of-benefits rules.	
Coverage outline	OAR 836-053-0060	An outline of benefits, policy limits, and cost-sharing provisions for the Small Employer Basic Plan is summarized as Exhibit 1 to OAR 836-053-0660.	
Credibility	ORS 742.005(2)(3), NAIC Discretionary Clause Model	If plan includes a discretionary clause, it does not give the insurer full and final discretion in interpreting its insurance contract. (Such a clause is considered to be inequitable, deceptive, and misleading to consumers.)	

Category	Reference	Description of review standards requirements	Page & paragraph
Definitions	ORS 743.801(5)*, OAR 836-053-1060	Definition of “grievance” as it applies to the grievance procedures.	
	ORS 743.730(3)	Terms identify the eligibility date for coverage and an affiliation period for health care service contractors.	
	ORS 743.730(8), OAR 836-053-0040	Creditable coverage is defined.	
	ORS 743.730(12), OAR 836-053-0021	Eligible employee definition meets the requirements of ORS 743.730(12) and OAR 836-053-0021.	
	ORS 743.730(14)	Definition of “enrollee” includes employee, dependent of the employee, or an individual otherwise eligible under the group.	
	ORS 106.340(2)(3)(4)	Definition of an “eligible dependent” must conform to ORS 743.730(10) and must be interpreted to include same sex domestic partners per ORS 306.340(2),(3), and (4).	
	ORS 743.730(15)	Describes exclusion period.	
	ORS 743.730(24)	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.	
	ORS 743.730(27)	Defines “pre-existing condition” as services, charges, or expenses incurred for pre-existing conditions for specified period immediately following enrollment. ( <i>Pre-existing conditions do not include:</i> <ol style="list-style-type: none"> <li>1. <i>Pregnancy, except as provided in ORS 743.766(2)(a)(C)(b).</i></li> <li>2. <i>Genetic information in the absence of a diagnosis.</i></li> <li>3. <i>A newborn child or adopted child who obtains coverage in accordance with ORS 743A.090.</i></li> <li>4. <i>A condition for which an ordinarily prudent person would have sought treatment or advice”.</i>)</li> </ol>	
ORS 742.005	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.		
Dental	ORS 743.736	Mandatory in Basic Plan: Coverage for children ages 3 to 12 years includes one exam, oral prophylaxis, and fluoride treatment each year; sealant in accordance with usual dental practice; and bitewing X-rays when deemed necessary by the attending dentist, but no more frequently than once every 18 months.	Yes <input type="checkbox"/> N/A <input type="checkbox"/>
		Mandatory in Basic Plan: Coverage includes treatment for accidental injury to sound natural teeth or jaw.	Yes <input type="checkbox"/> N/A <input type="checkbox"/>

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Dependent coverage	ORS 743.736	Mandatory in Basic Plan: Coverage includes immunizations.	Yes <input type="checkbox"/> N/A <input type="checkbox"/>
	ORS 743.736	Mandatory in Basic Plan: Coverage 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.	Yes <input type="checkbox"/> N/A <input type="checkbox"/>
	ORS 743A.090	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)	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.	
	Section 2714 of the PHSA/Section 1001 of the PPACA	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.	
Discrimination	ORS 743A.084	The policy does not discriminate between married and unmarried women or between children of married and unmarried women.	
Dollar limits	Section 2711 of the PHSA/Section 1001 of the PPACA	<b>Annual Limits</b> A plan may not impose annual dollar limits on essential benefits, except for policy years beginning prior to January 1, 2014.  Annual limits on essential benefits may be limited to: \$750,000 for plan years beginning 9/23/2010-9/23/2011 \$1.25 million for plan years beginning 9/23/2011-9/23/2012 \$2 million for plan years beginning 9/23/2012-12/31/2013mn	

Category	Reference	Description of review standards requirements	Page & paragraph
Dollar limits, continued	Section 2711 of the PHSA/Section 1001 of the PPACA	<p><b>Lifetime limits on essential benefits are prohibited.</b></p> <p>The essential health benefits cover the following general categories of services:</p> <ul style="list-style-type: none"> <li>• Ambulatory patient services</li> <li>• Emergency services</li> <li>• Hospitalization</li> <li>• Maternity and newborn care</li> <li>• Mental health and substance abuse disorder services, including behavioral health treatment</li> <li>• Prescription drugs</li> <li>• Rehabilitative and habilitative services and devices</li> <li>• Laboratory services</li> <li>• Preventive and wellness services and chronic disease management</li> <li>• Pediatric services, including oral and vision care</li> </ul>	
Eligibility	ORS 743.734(6), ORS 743.737(13)	Coverage is offered to all eligible employees.	
	ORS 743.737(14)	Policy provides for a special enrollment period.	
	ORS 743.837, OAR 836-053-1200	Policy describes prior authorization and binding periods.	
Emergency care	ORS 743.801(1)(2)(3)(8)*, ORS 743A.012(1)(c)	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(1)	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.	
	ORS 743.737(3), OAR 836-053-0060	The policy describes any exclusion period for specified covered services and its application to all individuals enrolling for the first time in a health benefit plan.	
	ORS 743.737(4)	Policy describes any late enrollee exclusion period, not to exceed 12 months.	

Category	Reference	Description of review standards requirements	Page & paragraph
Exclusions, continued	ORS 743.736, OAR 836-053-0060 General exclusions (mark "n/a" if not excluded and indicate page of coverage)	Benefits may exclude any service not medically necessary and appropriate.	
		Benefits may exclude custodial, convalescent, or intermediate-level care as determined by the carrier.	
		Benefits may exclude experimental or investigational procedures.	
		Benefits may exclude services that are the responsibility of the employer (workers' compensation) or a government body.	
		Benefits may exclude services for which no charges are made.	
		Benefits may exclude programs mandated by a court of law as a result of a court's findings, recommendation, or sentencing.	
		Benefits may exclude transportation, meals, and lodging necessary for recipient's access to covered services.	
		Benefits may exclude education, clinical programs, or medical/surgical services for weight control and food supplements or prescription medications used in conjunction with such program or service. Hospital/medical/ professional exclusions (mark "n/a" if not excluded and indicate page of coverage).	
		Benefits may exclude self help or training programs including, but not limited to, smoking cessation, weight control, nutrition and general fitness programs, and instruction for self-administering medications or operating durable medical equipment, except in the case of diabetic instructions provided on an outpatient basis.	
		Benefits may exclude plastic surgery or other cosmetic services that are indicated to improve appearance, except those that are the result of non-congenital injury or surgery including, but not limited to, cosmetic treatment of confirmed benign skin conditions, varicose veins, confirmed benign tumors, polyps and skin disease, and diseases of hair, nails, or follicles.	
		Benefits may exclude artificial insemination and other methods of conception by artificial means.	
		Benefits may exclude services for the reversal of elective surgically induced infertility.	
		Benefits may exclude vision services, except as noted for children through the age of 18.	
		Benefits may exclude surgery or other procedures that alter the refractive character of the eye.	
Benefits may exclude routine foot care.			
Benefits may exclude cochlear implants.			

Category	Reference	Description of review standards requirements	Page & paragraph
Exclusions, continued	ORS 743.736, OAR 836-053-0060 General exclusions (mark "n/a" if not excluded and indicate page of coverage)	Benefits may exclude medical and surgical services related to the treatment of TMJ except for splinting procedures.	
		Benefits may exclude ongoing medical treatment for certain conditions determined by the Oregon Health Services Commission to have minimal effectiveness.	
		Benefits may exclude external hearing aids and hearing devices, except for children younger than age 18 who experienced hearing loss before age three.	
		Benefits may exclude eyeglasses, contact lenses, and vision aids.	
		Benefits may exclude implantable pharmaceutical devices.	
		Benefits may exclude medical supplies and durable medical equipment prescribed on an outpatient basis and not specifically noted in covered services.	
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.	
Grandfathered Plans		1. Plan Materials- Plan Materials provided to a participant or beneficiary of a grandfathered plan describing the benefits must include a statement indicating: <ul style="list-style-type: none"> <li>the insurer believes the plan is a grandfathered plan under PPACA.</li> <li>grandfathered plans preserve certain basic health coverage that was already in effect.</li> <li>a grandfathered health plan may not include certain consumer protections.</li> <li>the grandfathered plan complies with PPACA consumer protections.</li> <li>customer service contact information.</li> </ul>	
		2. ERISA Plans include verbiage: <ul style="list-style-type: none"> <li>You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or <a href="http://www.dol.gov/ebsa/healthreform">www.dol.gov/ebsa/healthreform</a>. This website has a table summarizing which protections do and do not apply to grandfathered health plans.</li> <li>For individual market policies and non federal governmental plans insert: <ul style="list-style-type: none"> <li>You may also contact the U.S. Department of Health and Human Services at <a href="http://www.healthreform.gov">www.healthreform.gov</a>.</li> </ul> </li> </ul>	
Hospice	ORS 743.736, OAR 836-053-0060	Covers hospice care that includes medical supplies, drugs and medications, equipment and care for pain control, and symptom management during the insured's last six months of life.	
		Palliative care includes medical services that alleviate symptoms or afford temporary relief but do not cure.	

Category	Reference	Description of review standards requirements	Page & paragraph or Y/N
Hospital/ surgical/ medical expense	ORS 743A.080, OAR 836-053-0060	Hospital outpatient and ambulatory services include medical supplies used, drugs and medications required to be administered in, and casts applied in a hospital outpatient or ambulatory setting.	
	ORS 743A.080, ORS 743.823, OAR 836-053-0060	Hospital inpatient services include: <ol style="list-style-type: none"> <li>1. Delivery, post-partum, newborn care.</li> <li>2. Anesthesia.</li> <li>3. Medical supplies, drugs and medications, orthotics.</li> <li>4. Durable medical equipment.</li> <li>5. Functional medical equipment (e.g., pacemakers or artificial joints).</li> <li>6. Blood or blood products.</li> <li>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.</li> </ol>	
Limits	ORS 743.736, OAR 836-053-0060	Mandatory in Basic Plan: Provision describes benefit treatment limitation for ongoing medical treatment for confirmed irreversible hepatorenal syndrome.	Yes <input type="checkbox"/> N/A <input type="checkbox"/>
		Mandatory in Basic Plan: Coverage benefit is at least 50 percent and not subject to out-of-pocket maximums for the following: <ol style="list-style-type: none"> <li>1. Plastic surgery or other cosmetic services required as a result of a non-congenital injury or surgery.</li> <li>2. Orthognathic or arthroplastic surgery indicated for disorders resulting in impairment of speech, nutrition, or other bodily functions.</li> <li>3. Focal surgery for epilepsy.</li> </ol>	Yes <input type="checkbox"/> N/A <input type="checkbox"/>
Major medical expense	ORS 743.736, OAR 836-053-0060	Mandatory in Basic Plan: Policy provides coverage as follows for minimal history and examination, and screening exams for blood pressure, weight, and cholesterol levels: <ol style="list-style-type: none"> <li>1. Ages 19 years to 39 years, one exam every five years.</li> <li>2. Ages 40 years to 64 years, one exam every two years.</li> </ol>	Yes <input type="checkbox"/> N/A <input type="checkbox"/>
Managed care	ORS 743.845(1)(b)	Provision allows for the designation of a women's health care provider as the primary care physician, if a primary care physician is required.	
	ORS 743.845(2)	Provision permits a female enrollee to designate a women's health care provider as her primary care provider.	
	ORS 743.845(3)	Provision permits 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.	

Category	Reference	Description of review standards requirements	Page & Paragraph or check answer
Nursing home	ORS 743.736(2), OAR 836-053-0060	Mandatory in Basic Plan: Policy covers 20 days of skilled nursing facility (SNF) care per condition following inpatient hospitalization. SNF may also be provided under case management for catastrophic injury or illness.	Yes N/A <input type="checkbox"/> <input type="checkbox"/>
	ORS 743.736(2), OAR 836-053-0060	Mandatory in Basic Plan: Policy 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.	Yes N/A <input type="checkbox"/> <input type="checkbox"/>
Access to Pediatricians	Section 2719A of the PHSA/Section 10101 of the PPACA	Requires a non-grandfathered plan that mandates designation of a primary care physician to allow the policyholder to designate any willing in-network pediatrician as a child's primary care physician.	
Pre-existing conditions	ORS 743.737(1)	Pre-existing condition is a defined period prior to the effective date of coverage.	
	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 6 month period prior to enrollment; they terminate on the earlier of 6 months following effective date for new enrollees or 12 months for late enrollees.	
	ORS 743.737(3), OAR 836-053-0040	Credit for prior coverage reduces the pre-existing-condition period when creditable coverage did not end more than 63 days before enrollment.	
	ORS 743.737(3)	The policy describes any affiliation period for health care service contractors.	
	Sections 2704 of the PHSA/Section 1201 of the PPACA	A plan may not impose any preexisting condition exclusions. Plans may not impose any exclusion of benefits (including a denial of coverage) limit coverage based upon a preexisting condition, for an individual under age 19.	
Prescription drug	ORS 743A.062	If prescription drug coverage is offered, it does not exclude coverage of a drug because the drug is not FDA approved for a prescribed medical condition if the Oregon Health Resources Commission determines the use is effective.	
	ORS 743.736, OAR 836-053-0060	Mandatory in Basic Plan: Policy requires a co-payment 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.	Yes N/A <input type="checkbox"/> <input type="checkbox"/>

Category	Reference	Description of review standards requirements	Page & Paragraph or check answer
Preventive Services	Section 2713 of the PHSA/Section 1001 of the PPACA	For non-grandfathered plans, requires coverage and prohibits the imposition of cost-sharing for specified preventative services.  Non-grandfathered plans must provide coverage without cost-sharing for: <ul style="list-style-type: none"> <li>• Services recommended by the US Preventive Services Task Force</li> <li>• Immunizations recommended by the Advisory Committee on Immunization Practices of the CDC</li> <li>• Preventive care and screenings for infants, children and adolescents supported by the Health Resources and Services Administration</li> </ul> Preventive care and screenings for women supported by the Health Resources and Services Administration	
Proof of loss	OAR 836-080-0230 and 0235	If the policy includes claim procedures, the procedures and timelines comply with fair claim practice requirements.	
Requirements not part of a listed category	ORS 743.736, OAR 836-053-0060	Mandatory in Basic Plan: 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.	Yes <input type="checkbox"/> N/A <input type="checkbox"/>
	ORS 743.736, OAR 836-053-0060	Mandatory in Basic Plan: 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.	Yes <input type="checkbox"/> N/A <input type="checkbox"/>
		Mandatory in Basic Plan: Coverage for transplants includes liver, kidney, heart or lung, heart/lung, bone marrow for aplastic anemia, leukemia, and lymphoma; severe combined immunodeficiency disease or Wiskott-Aldrich syndrome; corneal, immunosuppressive drugs associated with covered transplant; and pancreas-kidney or pancreas after kidney.	Yes <input type="checkbox"/> N/A <input type="checkbox"/>
		Mandatory in Basic Plan: Covers supplemental services including dialysis (pre-ESRD eligible) and diabetic instructions provided on outpatient basis.	Yes <input type="checkbox"/> N/A <input type="checkbox"/>
Renewability	ORS 743.737(5), OAR 836-053-0001	Describes renewal, modification, or discontinuance provisions.	

Category	Reference	Description of review standards requirements	Page & Paragraph or check answer
Rescissions	Section 2712 of the PHSA/Section 1001 of PPACA	Coverage may be rescinded only for fraud or intentional misrepresentation of material fact as prohibited by the terms of the coverage. A plan must provide at least 30 days advance written notice to each participant who would be affected prior to rescinding coverage. 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.	
Small group defined	ORS 743.730(30)(a), OAR 836-053-0021(1)	Defines small employer group (2-50 employees)	
	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(5)	Describes contribution and participation requirements.	
Usual, customary, or reasonable defined	ORS 743.878(1)(b)	A written methodology of how allowable expenses are determined.	
Utilization review	ORS 743.807(2), OAR 836-053-1140	Utilization review requirements (prior authorization and appeal process).	
Vision	ORS 743.736, OAR 836-053-0060	Mandatory in Basic Plan: Coverage is provided for children through age 18 for one general eye examination, including necessary refractions, every 24 months.	Yes <input type="checkbox"/> N/A <input type="checkbox"/>
	ORS 743.842	If the plan coverages 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)	Policy describes the affiliation period limitation for health care service contractors on pre-existing conditions.	
	ORS 743.754(3)	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)	Policy defines the late enrollee exclusion.	
	ORS 743.754(5)	Policy provides for special enrollment periods.	