

Department of Consumer & Business Services

Oregon Insurance Division - 5

P.O. Box 14480
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**Standard Provisions for Group or Individual
Specified Disease – Limited Benefits, Sickness and Short Term Care.**

This checklist must be submitted with your filing, in compliance with OAR 836-010-0011(2). This list includes the 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: _____

Date: _____

- TOI (type of insurance):**
- | | | |
|--|-------------------------------------|-------------------------------------|
| <input type="checkbox"/> H07I Individual | <input type="checkbox"/> H07G Group | Specified Disease - Limited Benefit |
| <input type="checkbox"/> H13I Individual | <input type="checkbox"/> H13G Group | Short Term Care |
| <input type="checkbox"/> H18I Individual | <input type="checkbox"/> H18G Group | Sickness |

- Sub TOI:**
- | | | |
|---------------------------------------|------------------------------------|-----------------------------|
| <input type="checkbox"/> H07I.001 or | <input type="checkbox"/> H07G.001 | Critical illness |
| <input type="checkbox"/> H07I.002 or | <input type="checkbox"/> H07G.002 | Dread disease |
| <input type="checkbox"/> H07I.002A or | <input type="checkbox"/> H07G.002A | Dread Disease – Cancer Only |
| <input type="checkbox"/> H07I.003 or | <input type="checkbox"/> H07G.003 | HIV Indemnity |
| <input type="checkbox"/> H13I.001 | <input type="checkbox"/> H13G.001 | Home Health Care |
| <input type="checkbox"/> H13I.002 | <input type="checkbox"/> H13G.002 | Nursing Home |
| <input type="checkbox"/> H13I.003 | <input type="checkbox"/> H13G.003 | Adult Day Care |
| <input type="checkbox"/> H18I.000 or | <input type="checkbox"/> H18G.000 | Sickness |

Review requirements	Reference	Description of review standards requirements	Answer	
GENERAL REQUIREMENTS (FOR ALL FILINGS)				
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: www.oregoninsurance.org/docs/serff/filing_requirements.html . These must be submitted with your filing for your filing for it to be accepted as complete: 1. NAIC transmittal form.(paper filings only) 2. Filing description on transmittal form (cover letter). 3. Third party filer's letter of authorization. 4. Certificate of compliance form signed by authorized person. 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. 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.	Yes	N/A
	Filing description on transmittal form	The filing description (cover letter) includes the following: 1. Changes made to prior approved forms or variations from other approved forms. 2. Summary of the differences between prior approved like forms and the new form. 3. The differences between in-network and out-of-network, if applicable.	Yes	N/A
Review requested	ORS 742.003(1), OAR 836-010-0011(3)	The following are submitted in this filing for review: 1. New policy and certificate, if applicable. 2. Amendment to an approved form.	Yes	N/A
Applicability	Health-care-service contractors (HCSC)	Statute references followed by an asterisk (*), may be marked "N/A" in the location column if file for a HCSC. These standards do not apply to HCSC per ORS 750.055.		
	ORS 743.730(19)(a)	Coverages that are not exclusive to a condition, disease, or service and are not listed as an exclusion under ORS 743.730(19)(b) are Health Benefit Plans. (See product standards for Health Benefit Plans for filing those coverages.)		

Review requirements	Reference	Description of review standards requirements	Answer
Applicability, continued	ORS 743.565*, OAR 836-052-0800 to 0860	A carrier must mail a separate notice of cancellation 10 days prior to the end of the grace period.	
	Accidental death & dismemberment	If filing includes options for accidental death and dismemberment, product standards 440-3631 are included.	Yes <input type="checkbox"/> N/A <input type="checkbox"/>
Application	Form 440-2442H	If filing includes an application form that asks medical questions, product standards for health applications, 440-2442H, is included.	Yes <input type="checkbox"/> N/A <input type="checkbox"/>
Associations/trusts/discretionary groups	ORS 731.486, ORS 743.522, ORS 743.524	If filing includes issues to an association, trust, or discretionary group (Use form 440-2441.)	Yes <input type="checkbox"/> N/A <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 unintelligible, uncertain, ambiguous, abstruse, or likely to mislead.	Yes <input type="checkbox"/> N/A <input type="checkbox"/>
	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 3,000 words.	Yes <input type="checkbox"/> N/A <input type="checkbox"/>
Form numbers	ORS 743.405(7)	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. (See guidelines on our Web site: www.oregoninsurance.org/docs/healthun/health6.htm .)	Yes <input type="checkbox"/> N/A <input type="checkbox"/>
Variable text	ORS 742.003(1)	<ol style="list-style-type: none"> Variable data is indicated by brackets and all variable ranges or options are identified. Variability is limited to benefit data applicable to the owner or insured, benefits amounts, durations, and premium information. 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. (<i>Variable data may be included within the policy and certificate or may be submitted as a separate form identified by a form number and date.</i>) 	Yes <input type="checkbox"/> N/A <input type="checkbox"/>

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

GENERAL FORM REQUIREMENTS

Review requirements	Reference	Description of review standards requirements	Answer
Cover page	ORS 742.023, ORS 743.405(7) OAR 836-010-0011 ORS 743.405(7)	<ol style="list-style-type: none"> 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 signatures of at least two company officers appear 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 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Specifications page (Individual policies)	ORS 731.296, ORS 742.005(2) ORS 731.260	<ol style="list-style-type: none"> 1. The specifications page includes the benefit levels, premium information, and any other data applicable to the insured. 2. The specifications page is completed with hypothetical data that is realistic and consistent with the other contents of the policy. 3. Variable text is bracketed or otherwise marked to denote variability. 	Yes N/A <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
POLICY PROVISIONS			Page & paragraph
Applications	ORS 746.650(1)	Any adverse decision made in accepting or not accepting an applicant, including preliminary questions prior to filling out an application, are subject to the notification under ORS 746.650.	
Arbitration	ORS 36.600, ORS 36.715	Voluntary arbitration is permitted by the Oregon Constitution and statutes after all internal appeal levels and can be binding upon consent of the covered participant. (If the policy provides for arbitration when claim settlement cannot be reached, the enrollee may elect arbitration by mutual agreement at the time of the dispute. Arbitration takes place under the laws of Oregon or another agreed-upon procedure. Arbitration must be held in the insured's county and state.)	

Review requirements	Reference	Description of review standards requirements	Page & Paragraph
Beneficiaries	ORS 743.444	Individual policies. Policy states that unless the insured makes an irrevocable designation of beneficiary, the right to change beneficiary is reserved to the insured and the consent of the beneficiary shall not be requisite to surrender or assignment of this policy.	
Credibility	Discretionary Clauses ORS 742.005(4)	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.)	
Definitions	Emergency Care Definition ORS 743.801(1) ORS 743.801(2) ORS 743.801(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.	
	Usual, customary, or reasonable defined ORS 742.023	Filing includes a definition for "usual, customary, and reasonable" (UCR) that fully discloses how UCR benefits are determined. (<i>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.</i>)	
	Classes ORS 743.018 & ORS 742.005(2)	Individual policies. If the insurer uses class for the purpose of rating, the policy includes a definition of class that is consistent with the actuarial basis.	
Entire contract	ORS 743.411, ORS 742.016	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	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.	
Time limit on certain defenses	ORS 743.414(1)	Individual only: 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.	

Review requirements	Reference	Description of review standards requirements	Page & Paragraph
Time limit on certain defenses	ORS 743.414(2)	Individual only: The policy provision does not affect any legal requirement for avoidance of a policy or denial of a claim during the first two-year period or limit the application of ORS 743.450 to 743.462 in the event of misstatement with respect to age or occupation or other insurance.	
Incontestability	ORS 743.414(3), (4)	The “incontestable” statement in ORS 743.414(3) and (4) or a similar statement is included that states after two years from the date of issue of this policy, no misstatements except fraudulent misstatements made by the applicant shall be used to void the policy or to deny a claim, and losses after two years are covered.	
Fraud Warning	Bulletin 2010-03	Fraud or misstatement warnings that mention criminal or civil penalties must avoid definite statements of the criminal nature of an act, guilt, or possible penalties. A warning that specifies that knowingly providing false information “may be” a crime, which “may be” grounds for criminal or civil penalties is appropriate.	
Legal action	ORS 743.441	Provision states that no action at law or in equity is brought to recover on this policy prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the policy. No action shall be brought after the expiration of three years after the time written proof of loss is required.	
Physical examination/ autopsy	ORS 743.438	The “physical examinations and autopsy” statement in ORS 743.438 or a similar statement is included in the policy, explaining that the insurer at its own expense shall have the right and opportunity to examine the insured when and as often as it may reasonably require while a claim is pending.	
Grace period	ORS 743.417 for individual and ORS 743.560 for Group policies	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.	
Pre-existing conditions	Implementation of HIPAA and federal regulations ORS 743.758	Pre-existing conditions provisions shall not be applied more restrictively than those stipulated under the Health Insurance Portability and Accountability Act of 1996 (HIPAA)	
	42 U.S.C.300gg (Group/Individual) ORS 742.023	HIPAA limits the preexisting condition exclusion period to 12 months (18 months for a late enrollee) and “creditable coverage” will reduce the pre-existing exclusion period. Pre-existing condition is a defined period prior to the effective date of coverage.	

Review requirements	Reference	Description of review standards requirements	Page & Paragraph
Discrimination	Married and Unmarried women ORS 743A.084	The policy does not discriminate between married and unmarried women or between children of married and unmarried women.	
	Discrimination against Physical Disability ORS 746.015(2)	This contract complies with ORS 746.015(2) by not discriminating in its underwriting standards and or rates solely on an individual's physical disability.	
	Discrimination against Age 65 ORS 746.015(3)	This contract complies with ORS 746.015(3) by not discriminating against a person who attains or exceeds age 65, unless such discrimination is based on clear and sound actuarial principals as well as anticipated experience.	
	Discrimination against Domestic Violence ORS 746.015(4)	This contract complies with ORS 746.015(4) by not cancelling, refusing to issue or renew this policy on the basis of the fact that an insured or prospective insured is or has been a victim of domestic violence.	
	Same-sex domestic partnerships Bulletin 2008-02 ORS 106.305(4) (Group/Individual)	All Group and Individual health insurance policies must offer the same benefits to Same-sex domestic partnership as they do married couples. A domestic partnership is defined in section 3, ch. 99, Oregon Laws 2007 to mean "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."	
Proof of loss	ORS 743.429	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. <i>(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.)</i>	
	OAR 836-080-0230 and 0235	If the policy includes claim procedures, the procedures and timelines comply with fair claim practice requirements.	
Claim forms	ORS 742.053, ORS 743.426	The "claim forms" statement in ORS 743.426, or a similar statement, is included in the policy, providing that, if claim forms are required and are not furnished within 15 days after the claimant gives notice of claim, the claimant shall be deemed to have complied with the requirement of the policy	

Review requirements	Reference	Description of review standards requirements	Page & Paragraph
Claim notice	ORS 743.423(1)	The “notice of claim” statement in ORS 743.423(1), or a similar statement, is included in the policy, explaining that written notice of claim is given to the insurer within 20 days after occurrence or commencement of any loss covered by the policy or as soon thereafter as is reasonably possible.	
Claim payment	ORS 743.432	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.	
	ORS 743.435	Individual policies. Policy states that benefits paid for loss of life are payable in accordance with the beneficiary designation. If no such designation or provision is in effect, such payments shall be payable to the estate of the insured.	
Coordination of benefits (COB)	ORS 743.549, ORS 743.552, OAR 836-020-0700 to 0765	Group policies. If policy applies coordination of benefits, it complies with ORS 743.549, ORS 743.552, and OAR 836-020-0700 to 0765.	
		Group policies. Reduction of benefit payments on the basis of other insurance for the insured individual is in full accordance with coordination-of-benefits rules.	
Dependent coverage	Bulletin 2008-02 on HB 2007 ORS 106.305(4)	If dependent coverage is offered, the contract must include same sex domestic partners as eligible dependents. Per HB 2007 all benefits provided to married spouses, must equally be offered to registered domestic partners.	
	Newborn and Newly adopted children. 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.	
	Children out of wedlock 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.	
Exclusions	ORS 743.847(2)	Eligibility for benefits is not determined based on eligibility for Medicaid.	
Cancellation & nonrenewal	ORS 743.498, ORS 743.495	Individual policies. A non-cancelable or guaranteed renewable policy includes the statement required by ORS 743.498 or similar language explaining the guaranteed or cancelable periods.	
	ORS 743.560(3), (4)	Group policies. If policy provides benefits for hospital or medical expenses, other than accident or specific diseases, notification of non-replacement rights is sent to the policyholder no later than 10 days after the termination date.	

Review requirements	Reference	Description of review standards requirements	Page & Paragraph
Reinstatement	ORS 743.420	A provision states that if the renewal premium has not been paid within the time granted but an insurer or authorized agent subsequently accepts a premium the policy shall be reinstated. The only exception is an application for reinstatement required to be submitted by the enrollee and accepted by the insurer.	
Renewability	ORS 743.018, ORS 742.023	Individual policies. 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 Insurance Division.	

REQUIREMENTS FOR RATES FOR INDIVIDUAL POLICIES *(Information requested under this section is determined to be necessary to evaluate the filing for compliance. ORS 731.296)*

Filing request	ORS 731.296	The following review is requested: 1. New rate filing. 2. Rate change. 3. Informational.	Requested <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Payment plans	ORS 746.005(6)	Payment options such as salary savings, bank draft, pre-authorized check, or payroll-deduction of similar plan are offered at a reduced rate based on cost savings to the insurer.	Yes No <input type="checkbox"/> <input type="checkbox"/>
Requirements not part of a listed category	ORS 743.018, ORS 742.005(6)	Premium changes are subject to prior approval and should not be filed more than once in a 12-month period.	Yes <input type="checkbox"/>
	ORS 742.041	Combined classes. This filing includes classes of combined life and health insurance. <i>(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.)</i>	Yes <input type="checkbox"/>
Ratemaking generally	ORS 731.296, OAR 836-010-0011	Appendix A (form 440-2462) is included and all columns completed showing support of the rate change requested; it includes actual and projected experience and overall loss ratio from policy inception for Oregon and the company's national experience. (See Web site: http://www.oregoninsurance.org/docs/serff/individual_health.htm)	Yes <input type="checkbox"/>
		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. <i>(Include a description of the risk and the assumptions used in developing the cost.)</i>	Yes <input type="checkbox"/>

Review requirements	Reference	Description of review standards requirements	Answer
		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 <input type="checkbox"/>
		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 <input type="checkbox"/>
		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 <input type="checkbox"/>
Ratemaking generally continued	ORS 731.296, OAR 836-010-0011	A statement that the grouping of policy forms has not changed or an explanation of the changes is included. Experience of forms must be grouped according to similar types of benefits, claims experience, reserves, margins for contingencies, expenses and profit, renewability, underwriting, and equity between policyholders.	Yes <input type="checkbox"/>
	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 <input type="checkbox"/>
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 <input type="checkbox"/>
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 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>