Checklist for Individual and Small Group Health Insurance Plans - Policy Form
Inside and Outside the Rhode Island Health Benefit Exchange
Effective for plan years beginning on and after 1-1-2014

Company Name:		Issuer is: ☐ certified by the Health Benefits Exchange as a QHP issuer ☐ licensed by OHIC to do health insurance business in RI
Product Name:		
Plan Name:		
SERFF tracking number:		
TOI Code and Sub Code:		

☐	60% AV (Bronze)
☐	70% AV (Silver)
☐	80% (Gold)
☐	90% (Platinum)
☐	Child-only
☐	Catastrophic Plan - 42 U.S.C. § 18022(e)
	Filed for issuance: Inside the Exchange ☐ Outside the Exchange ☐ Inside and Outside the Exchange ☐

Individual Market ☐ Small Group Market ☐ SHOP ☐

Instructions for Checklist:

A. The Checklist for Individual and Small Group Health Insurance Plans ("Checklist") must be completed for all major medical health insurance plan policy forms offered by a health insurance issuer (“Issuer”) in the individual market and in the small group market, including individual Qualified Health Plans (“QHP’s”) and SHOP QHP’s offered on the Rhode Island Health Benefit Exchange (“Exchange”).
B. The Checklist does not apply to large group health insurance plans, dental plans, or Medicare Supplemental insurance plans.
C. The terms of applicable laws and regulations shall supersede this Checklist in the case of a conflict. The omission of any requirement of the law or of a regulation from this Checklist in no way limits the authority of the Office of the Health Insurance Commissioner to enforce any other such requirement.
D. A filer shall not change or revise the Checklist.
E. By checking the "Yes" box, the Issuer certifies that the referenced provision of the health insurance plan ("Plan") complies with the associated requirement, and that the referenced provision does not contain any inconsistent, ambiguous, unfair, inequitable, or misleading clauses, or exceptions of conditions that unreasonably affect the risk purported to be assumed.

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F. By checking the box "N/A", the Issuer certifies that Plan does not have to comply with the associated requirement. An Explanation must be provided if this box is checked.

G. This Checklist is established by the Commissioner of the Office of the Health Insurance Commissioner ("OHIC") pursuant to OHIC Regulation 17 - "Filing and Review of Health Insurance Plan Forms and Rates." The Checklist is intended to communicate the Commissioner's considered opinion concerning what a Plan form must contain in order to satisfy the statutory and regulatory standards for approval of the form. See R.I. Gen. Laws §§ 27-18-8, 27-19-6, 27-20-6, and 27-41-29.2.

H. The Commissioner may revise the Checklist from time to time. The Checklist, and any revisions to the Checklist, will be posted on SERFF as Filing Instructions for Rhode Island.

I. The filing shall include an actuarial memorandum demonstrating the calculation and analysis used to determine: (a) the Plan's actuarial value rating, and if applicable, (b) the Plan's Catastrophic Plan status, (c) the actuarial equivalence of Essential Health Benefit substitutions, and (d) the conversion of annual or lifetime dollar limits for Essential Health Benefits to a permitted limitation.

Requirement	Federal and/or State Law Authority	Reference to Page, Section and Para. of the Plan	Yes	N/A
General Requirements				
1. The filing must contain the entire health insurance plan policy form. • If the filer requests approval of any section, paragraph or other text in the Plan based on prior approval of the text by OHIC, the filer must identify the previously approved filing, and the page, section and paragraph where the text appears in the previously approved filing.	RI Gen Law §§ 27-18-8, 27-19-6, 27-20-6, 27-41-29.2. OHIC Regulation 17		☐ ☐	☐ ☐
Explanation:				
2. If changes to a previously approved form are filed, the filing shall include a red-lined version of the previously approved form, and a clean version of the form as proposed to be amended.	RI Gen Law §§ 27-18-8, 27-19-6, 27-20-6, 27-41-29.2. OHIC Regulation 17		☐	☐
Explanation:				
3. All forms must be filed in a word-searchable format.	RI Gen Law §§ 27-18-8, 27-19-6, 27-20-6, 27-41-29.2 OHIC Regulation 17		☐	☐

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Explanation:				
4. Readability. • Forms must comply with the requirements of OHIC Regulation 5, "Standards for the Readability of Health Insurance Forms". • The filing must include a Readability Certification in accordance with OHIC Regulation 5.	45 CFR §156.265(e) RI Gen Law §§ 27-18-8, 27-19-6, 27-20-6, 27-41-29.2 OHIC Regulation 5		☐ ☐	☐ ☐
Explanation:				
5. The filing must include the "Compliance Attestation - Forms", attached hereto as Exhibit A.	RI Gen Law §§ 27-18-8, 27-19-6, 27-20-6, 27-41-29.2. OHIC Regulation 17.		☐	☐
Explanation:				
Standard Policy Provisions 6. The Plan complies with state laws and regulations relating to: • The Form of the Plan. • Required Provisions • Individual Health Benefit Contracts • Group and Blanket Health Benefit Contracts	 R.I. Gen. Laws § 27-18-2 R.I. Gen. Laws § 27-18-3 OHIC/DBR Regulation 23, Part VII OHIC/DBR Regulation 23, Part VIII		 ☐ ☐ ☐ ☐	 ☐ ☐ ☐ ☐
Explanation:				

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Form Content Requirements				
7. Essential Health Benefits ("EHB") a) The Plan must cover each of the 10 categories of Essential Health Benefits: o Ambulatory patient services o Emergency services o Hospitalization o Maternity and newborn care o Mental health and substance use disorder services, including behavioral health treatment o Prescription drugs o Rehabilitative and habilitative services and devices o Laboratory services o Preventive and wellness services and chronic disease o Pediatric services, including oral and vision care b) The provisions of this Section 7 apply to benefits and services covered under the Plan. The provisions of this Section 7 do not apply to cost sharing, and do not apply to utilization review standards and procedures. c) The Plan must cover each and every service covered in the EHB-Benchmark Plan. The components of the EHB-Benchmark Plan are: (1) the Blue Cross Vantage Blue Small Group plan ("the Base-Benchmark Plan"), including the prescription drug benefits covered by the Base-Benchmark Plan; (2) the pediatric dental benefits covered under the MetLife Federal Dental plan; (3) the pediatric vision benefits covered under the FEP Blue Vision plan; and (4) habilitative services as determined and required by subsection (h), below. **Note:** OHIC considers each of the benefits and services covered in the Base-Benchmark Plan to be included within one of the 10 Essential Health Benefits listed in subsection	42 U.S.C. § 18022 45 C.F.R. § 156.100 et seq.		☐ ☐	☐ ☐

Requirement	Federal and/or State Law Authority	Reference to Page, Section and Para. of the Plan	Yes	N/A
(a), above. If the filer proposes to exclude a benefit or service covered in the R.I. Benchmark Selections, because the filer considers the benefit or service to be not included within one of the 10 Essential Health Benefits listed in subsection (a), above, the filer must identify such benefit or services, and provide a written explanation for the exclusion. The components of the EHB-Benchmark Plan (other than habilitation services required by subsection (h), below, can be found at the following address on the OHIC website: http://www.ohic.ri.gov/2010%20Health_Reform.php				
d) The Plan must cover the services covered in the EHB-Benchmark Plan, including but not limited to each and every state benefit mandate covered in the Base-Benchmark Plan.			☐	☐
e) Prescription drugs.				
○ The filer must include the Plan's prescription drug formulary with the filing.			☐	☐
○ The Plan must cover the greater of: (i) one drug in each United States Pharmacopeia ("USP") category or class, or (ii) the same number of prescription drugs covered in the Base-Benchmark Plan.			☐	☐
○ The Plan may substitute a prescription drug covered under the Base-Benchmark Plan, provided that the substituted drug covered under the Plan is in the same USP category or class as the drug covered under the Base-Benchmark Plan. The Issuer shall identify any drug substitutions, and shall verify that the therapeutic category or class of the substituted drug covered under the Plan is the same as the therapeutic category or class of the drug covered under the Base-Benchmark Plan. In the case of formulary substitutions during the Plan year, the Issuer shall file on SERFF a notification (not subject to prior approval) identifying the substitution that has			☐	☐

Requirement	Federal and/or State Law Authority	Reference to Page, Section and Para. of the Plan	Yes	N/A
been made, and verifying that the USB category or class of the substituted drug covered under the Plan is the same as the USP category or class of the drug covered under the Base-Benchmark Plan. o The Plan shall describe the process for an enrollee to request and receive coverage of clinically appropriate drugs not on the Plan's formulary.			☐	☐
f) A Plan that is offered outside the Exchange must cover the pediatric dental services covered by the EHB-Benchmark Plan (the MetLife Federal Dental plan for federal employees), for enrollees 18 years of age or younger; except that a Plan that is offered outside the Exchange is not required to cover the pediatric dental services covered by the EHB-Benchmark Plan if the Issuer determines, after reasonable inquiry, that the individual or small group policyholder is covered under a dental insurance plan that covers the pediatric dental services covered by the EHB-Benchmark Plan. If the individual or small group policyholder is already covered under a dental insurance plan that covers the pediatric dental services covered by the EHB-Benchmark Plan, the Issuer shall not offer the Plan with pediatric dental services; instead, the Issuer must offer a Plan that excludes pediatric dental coverage, with a premium discount equivalent to the per member per month cost of pediatric dental coverage. The Issuer's rate filing for the Plan shall include the proposed premium for the Plan with and without pediatric dental services.			☐ ☐	☐ ☐
g) The Plan must cover the pediatric vision services covered under EHB-Benchmark Plan (the FEP Blue Vision plan for federal employees) for enrollees 18 years of age or younger.			☐	☐
h) The Plan must cover habilitative services as approved by the Commissioner, in accordance with the following: Habilitative services covered under the Plan must be defined by scope, and			☐	☐

Requirement	Federal and/or State Law Authority	Reference to Page, Section and Para. of the Plan	Yes	N/A
must be at least as comprehensive (measured by per member per month cost) as the per member per month cost of rehabilitation services covered under the plan. Service visit limitations or other durational or quantitative limitations will be approved by the Commissioner only if the filer can demonstrate that no other qualitative, evidenced-based limitations less burdensome to the consumer (e.g. a process for developing limitations based on individual assessments of need) are feasible and appropriate. The filer must attach in the filing an Exhibit that (1) identifies the habilitative services covered by the plan, (2) includes an actuarial memorandum estimating the per member per month cost of the habilitative and rehabilitative services covered, and (3) includes in the actuarial memorandum the calculation and analysis used to develop the identified cost. No later than 90 days after the end of each calendar year, the Issuer must file with OHIC an actuarial memorandum, using the best available claims data, describing the Plan's claims and expense experience for habilitative and rehabilitative services during the preceding Plan year, and comparing such claims and expense experience with the approved rate factor.			☐	☐
i) Substitutions. o A Plan may substitute a benefit or service for a benefit or service covered under the EHB-Benchmark Plan only if: (1) the Plan's substitute benefit or service is included within the same Essential Health Benefit category (see subsection (a), above) as the benefit or service covered under the EHB-Benchmark Plan; (2) the substitute benefit or service and the substituted benefit or service are actuarially equivalent; and (3) the substitution is approved by the Commissioner.			☐	☐
o The filer must identify the substitution, and must file an actuarial memorandum demonstrating that the substitution is actuarially equivalent.			☐	☐

Requirement	Federal and/or State Law Authority	Reference to Page, Section and Para. of the Plan	Yes	N/A
j) A Plan may include a material deviation from a benefit or service for a benefit or service covered under the EHB-Benchmark Plan only if (1) the deviation is identified; (2) the Issuer files a memorandum demonstrating that the deviation is substantially equivalent to the EHB-Benchmark Plan; and (3) the deviation is approved by the Commissioner.			☐	☐
Explanation:				
8. Cost-sharing. • Out of pocket limits. The Issuer must demonstrate in an Exhibit filed with the Plan that annual out of pocket cost sharing under the Plan does not exceed the limits established by federal and state laws and regulations, including any revisions to this Checklist. • Deductible limits. For small group Plans, the Issuer must demonstrate in an Exhibit filed with the Plan that annual deductibles under the Plan do not exceed the limits established by federal and state laws and regulations, including any revisions to this Checklist.	42 U.S.C. § 18022(c) 45 C.F.R. § 156.130(a)		☐ ☐	☐ ☐
Explanation:				
9. The Plan must contain no preexisting condition exclusions.	42 U.S.C. § 300gg-3 RI Gen Law §§ 27-18-71, 27-18.5-10, 27-19-68, 27-20-57, 27-41-81		☐	☐
Explanation:				

Requirement	Federal and/or State Law Authority	Reference to Page, Section and Para. of the Plan	Yes	N/A
10. Lifetime dollar limits. • The Plan must contain no lifetime limits on the dollar value of any Essential Health Benefits, including the specific benefits and services covered under the EHB-Benchmark Plan. See Para. 7, above. • If the specific benefits and services covered under the Base-Benchmark Plan (See Para. 7, above) include dollar limits on the coverage of any such benefit or service, the Plan may propose an actuarially equivalent conversion of the dollar limit to a utilization limit, or some other quantitative or qualitative limit, subject to the Commissioner's approval. • If the Plan proposes a conversion the Issuer must file with the Plan an actuarial memorandum supporting the actuarially equivalent conversion.	PHSA §2711 45 CFR §147.126 RI Gen Law §§ 27-18-8, 27-19-6, 27-20-6, 27-41-29.2		☐ ☐ ☐	☐ ☐ ☐
Explanation:				
11. Annual dollar limits. a) The Plan must contain no lifetime limits on the dollar value of any Essential Health Benefits, including the specific benefits and services covered under the EHB-Benchmark Plan. See Para. 7, above. b) If the specific benefits and services covered under the Base-Benchmark Plan (See Para. 7, above) include dollar limits on the coverage of any such benefit or service, the Plan may propose an actuarially equivalent conversion of the dollar limit to a utilization limit, or some other quantitative or qualitative limit, subject to the Commissioner's approval. **c)** If the Plan proposes a conversion the Issuer must file with the Plan an actuarial memorandum supporting the actuarially equivalent conversion.	42 U.S.C. § 300gg-11 45 CFR §147.126 RI Gen Law §§ 27-18-8, 27-19-6, 27-20-6, 27-41-29.2		☐ ☐ ☐	☐ ☐ ☐
Explanation:				

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12. The Plan must state that the Issuer may not rescind the Plan except in cases of fraud or intentional misrepresentation of material fact. The Plan must also state that coverage may not be contested 2 years after issuance of the Plan for any reason. • Rescission is a cancellation of coverage that has retroactive effect. It includes a cancellation that voids benefits paid. • Coverage may not be rescinded except with 30 days prior notice to each enrolled person who would be affected.	42 U.S.C. § 300gg-12 45 CFR §147.128 RI Gen Law §§ 27-18-8, 27-18-72, 27-19-6, 27-19-62, 27-20-6, 27-20-58, 27-41-29.2 OHIC/DBR Reg. 23 Part VIII, Section 1(2)		☐	☐
Explanation:				
13. The Plan must cover preventive services without cost sharing requirements including deductibles, co-payments, and co-insurance. • Covered preventive services include: o Evidence-based items or services that have in effect a rating of A or B in the current recommendations of the USPSTF; o Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices (CDC); o Evidence-informed preventive care and screenings provided for in HRSA guidelines for infants, children, adolescents, and women; and o Current recommendations of the USPSTF regarding breast cancer screening, mammography, and prevention.	PHSA §2713 45 CFR §147.130 RI Gen Law §§ 27-18-8, 27-19-6, 27-20-6, 27-41-29.2		☐	☐
Explanation:				
14. The Plan must provide coverage for dependents up to age 26 if the Plan offers dependent coverage. • Eligible children are defined based on their relationship with the participant.	42 U.S.A. § 300gg-14 45 CFR §147.120		☐	☐

Requirement	Federal and/or State Law Authority	Reference to Page, Section and Para. of the Plan	Yes	N/A
• Limiting eligibility is prohibited based on: o financial dependency on primary subscriber, o residency, o student status, o employment, o eligibility for other coverage, o marital status. • Terms of the policy for dependent coverage cannot vary based on the age of a child.	RI Gen Law §§ 27-18-59, 27-19-50, 27-20-45, 27-41-61			
Explanation:				
15. The Plan must cover emergency services in accordance with the following: • No prior authorization. • No limitation to only services and care at participating providers. • Must cover at in-network cost-sharing level (patient is not penalized for emergency care at out-of-network provider). • Must pay for out-of-network emergency services the greatest of: (1) The median in-network rate; (2) the usual customary and reasonable rate (or similar rate determined using the plans or issuer's general formula for determining payments for out-of-network services); or (3) the Medicare rate.	42 U.S.C. § 300gg-19a(b) 45 CFR §147.138 RI Gen Law §§ 27-18-76, 27-19-66, 27-20-62, 27-41-79 SSA §1395dd		☐	☐
Explanation:				
16. For network plans requiring a primary care provider to be designated and requiring referrals: • The Plan must allow each enrollee to designate any participating primary care provider who is available to accept such individual. • The Plan must permit a physician specializing in pediatrics to	42 U.S.C. § 300gg-19a(a), (c), and (d) 45 CFR §147.138		☐	☐

Requirement	Federal and/or State Law Authority	Reference to Page, Section and Para. of the Plan	Yes	N/A
be designated as primary care provider. • The Plan must not require a referral for services to be provided by in-network OB/GYNs. The Plan must treat the ordering of OB/GYN items or services by an OB/GYN as it had been ordered or authorized by the primary care provider.	RI Gen Law §§ 27-18-44		☐ ☐	☐ ☐
Explanation:				
17. In connection with maternity coverage, the Plan must provide coverage as follows: • Benefits may not be restricted to less than 48 hours following a vaginal delivery, and 96 hours following a cesarean section. This requirement does not apply if the provider, in consultation with the mother, decides to discharge the mother or the newborn prior to the minimum length of stay. • No prior authorization required for the minimum hospital stay. • For purposes of maternity coverage requirements, hospital length of stay begins at the time of delivery if delivery occurs in a hospital and at time of admission in connection with childbirth if delivery occurs outside the hospital. • No denial of mother/newborn eligibility, continued eligibility, to enroll or to renew coverage to avoid these requirements. • No monetary payments or rebates to encourage mothers to accept less than the minimum stay requirements. • No penalty for an attending provider who provides services in accordance with these requirements. • No incentives to an attending provider to induce the provider to provide care inconsistent with these requirements. • No restriction of benefits for any portion of a period within the minimum stay periods in a manner less favorable than the benefits provided for any preceding portion of such stay. • No requirement that the mother give birth in a hospital.	42 U.S.C. § 300gg-25 45 CFR §148.170 RI Gen Law §§ 27-18-33.1, 27-19-23.1, 27-20-17.1, 27-41-33.1, 27-41-43 RI Gen Law §§ 27-18-8, 27-19-6, 27-20-6, 27-41-29.2		☐ ☐	☐ ☐

Requirement	Federal and/or State Law Authority	Reference to Page, Section and Para. of the Plan	Yes	N/A
• No requirement that the mother to stay in the hospital for a fixed period of time following the birth of her child.				
Explanation:				
18. The Plan must state that it provides, and must provide coverage for parity in mental health and substance use disorder benefits ("Parity"), in accordance with the following: • Coverage for the medical treatment of mental illness and substance abuse must be provided under the same terms and conditions as that coverage is provided for other illnesses and diseases. • The Plan must describe, through illustrations, FAQ's, or other consumer explanation how the Plan provides for Parity in connection with financial requirements, quantitative treatment limitations, prescription drug benefits, and non-quantitative treatment limitations.	42 U.S.C. § 300gg-26 45 CFR §146.136 RI Gen Law § 27-38.2-1		☐	☐
Explanation:				
19. The Plan must provide coverage for reconstructive surgery after mastectomy (Women's Health and Cancer Rights Act). The Plan must describe, through illustrations, FAQ's, or other consumer explanation how the Plan covers reconstructive surgery after mastectomy, including the scope of coverage, and cost-sharing consistent with other medical/surgical benefits.	PHSA §2727 RI Gen Law §§27-8-39, , 27-20-29, 27-41-43 OHIC Reg. 17		☐	☐
Explanation:				
20. The Plan must state that coverage is guaranteed renewable, and that the Issuer may non-renew or cancel coverage under the Plan only for nonpayment of premiums, fraud, market exit, movement outside of service area, or cessation of bona-fide association membership.	PHSA §2702 45 CFR §148.122		☐	☐

Requirement	Federal and/or State Law Authority	Reference to Page, Section and Para. of the Plan	Yes	N/A
	RI Gen Law § 27-18.5-4			
Explanation:				
21. The Plan must state that it does not limit coverage based on genetic information. 22. The Plan must state that the Issuer will not: (i) adjust premiums based on genetic information; (ii) request /require genetic testing; (iii) or collect genetic information from an individual prior to, or in connection with enrollment in a plan, or at any time for underwriting purposes.	PHSA §2753 45 CFR §148.180 RI Gen Law §§ 27-18-8, 27-19-6, 27-20-6, 27-41-29.2		☐ ☐	☐ ☐
Explanation:				
23. The Plan must provide coverage for individuals participating in approved clinical trials. The Plan must describe, through illustrations, FAQ's, or other consumer explanation how the Plan provides such coverage, including the scope of coverage, individuals qualified, clinical trials that will be approved, and network provider limitations.	42 U.S.C. § 300gg-8 RI Gen Law §§ 27-18-74, 27-19-64, 27-20-60, 27-41-77		☐	☐
Explanation:				
24. The Plan must state that the enrollee may terminate coverage upon no greater than 14 days notice to the Issuer or the Exchange. 25. For QHPs only, the Plan must state that the Issuer is permitted to terminate coverage if: • The enrollee is no longer eligible for coverage through the Exchange. • Payment of premiums cease (after appropriate grace periods	45 CFR § 155.430 45 CFR § 156.270(d) - (g) RI Gen Law §§ 27-18-8, 27-19-6, 27-20-6, 27-41-29.2 RI Gen Law § 27-18-3(a)(3);		☐ ☐	☐ ☐

Requirement	Federal and/or State Law Authority	Reference to Page, Section and Para. of the Plan	Yes	N/A
applied as described below); • The enrollee's coverage is rescinded for a non-prohibited reason. • The Qualified Health Plan is terminated or decertified. • The enrollee changes from one plan to another through during an open or special enrollment period. 26. The Plan must state that if coverage is terminated, 30 days prior notice is required, and the notice must include the reason for termination. 27. The Plan must state that a 3 month grace period is provided for enrollees in a Qualified Health Plan who are recipients of advance payments of premium tax credit. The Issuer must provide the enrollee with notice of payment delinquency, unless the Exchange has accepted the obligation to do so on behalf of the Issuer. 28. For all other enrollees, the Plan must state that a 30 day grace period is provided.			☐ ☐ ☐	☐ ☐ ☐
Explanation:				
Claims, Internal Appeals, and External Appeals 29. The Plan must include a description of its claims procedures, procedures for obtaining prior approval, preauthorization procedures, utilization review procedures, adverse benefit determination procedures, internal appeals, external appeals, and **t**he applicable time frames for these policies and procedures. Such policies and procedures must be in accordance with federal laws and regulations, in accordance with state laws and regulations that are not in conflict with such federal laws and regulations, and in accordance with the requirements of this checklist. 30. The Plan must include the standards, including the Plan's medical	42 U.S.C. § 300gg-19 45 CFR § 147.136 RI Gen Law §§ 27-18-8, 27-19-6, 27-20-6, 27-41-29.2 RI Gen Law §§ 23-17.12-1 et seq., 23-17-13-1 et seq. (where not in conflict with federal laws and regulations).		☐ ☐	☐ ☐

Requirement	Federal and/or State Law Authority	Reference to Page, Section and Para. of the Plan	Yes	N/A
necessity standard, applicable to prior approval, preauthorization, and utilization review procedures. The Plan's definition of "medical necessity" must: • Require coverage of health care services that are appropriate, in terms of type, amount, frequency, level, setting, and duration to the member's diagnosis or condition. • Must be informed by generally accepted medical or scientific evidence and consistent with generally accepted practice parameters.	DOH Regulations 23-17-12-UR and 23-17.13-CHP (where not in conflict with federal laws and regulations).			
31. The Plan must explain to the enrollee how to obtain the clinical review criteria used to determine medical necessity in a particular situation.			☐	☐
32. The Plan's definition of adverse benefit determination must be the definition used in 29 C.F.R. § 2560.530-1. The term also includes a rescission of coverage.			☐	☐
33. In connection with external appeals, the Plan must provide that: • The cost of an external appeal must be borne by the issuer. • The claimant must not be charged a filing fee greater than $25. • Restrictions on the minimum dollar amount of a claim are not allowed. • The decision of the Independent Review Organization is binding on the issuer.			☐	☐
Explanation:				