

## Form Filing Checklist - Group Health-Comprehensive

TOIs: H04 Health – Blanket Accident & Sickness  
 H15G Group Health – Hospital/Surgical/Medical Expense  
 H16G Group Health – Major Medical  
 HOrg02G Group Health Organizations-Health Maintenance (HMO)

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### DISCLAIMER

*The form filing checklists are intended only as guides for submitting various policy forms to the Office of the Commissioner of Insurance (OCI). The checklists are summaries, and are not intended as an OCI directive nor to interpret or address technical legal questions. Although efforts have been made to ensure that the checklists are current and accurate, information is subject to change on a regular basis without prior notice.*

The cites in the second column reference Wisconsin statutes unless they begin with “Ins” which indicates an administrative code [regulation]

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General Filing Requirements	Reference	Comments
Policy Form Transmittal Document	Ins 6.05(4)(a)1	Forms and instructions are available on the NAIC website at this link: <a href="http://www.naic.org/industry_rates_forms_trans_docs.htm">http://www.naic.org/industry_rates_forms_trans_docs.htm</a>
Filing Description (SERFF)	Ins 6.05(4)(a)3a	Include a brief explanation of use and intent of the form filing, or that identifies amendments to prior policy form submissions
Certificate of Compliance and Readability	Ins 6.05(4)(a)2 Ins 6.05 Appendix A	For SERFF submissions, include information identified in SERFF filing rules and instructions.
Statement of Variability	Ins 6.05(4)(a)5	If a form contains variable material or language, a written description identifying the range of the variable material or language.
Policy Language Simplification - Readability	Ins 6.07(4)	Readability score for each form shall be stated in the cover letter or as a data element in a SERFF filing.
Pediatric Dental Benefit Disclosure		BULLETIN April 2, 2013, <a href="http://oci.wi.gov/bulletin/0413peddental.htm">http://oci.wi.gov/bulletin/0413peddental.htm</a>
Drug Formulary		This is required to be submitted as supporting documentation with the annual policy form filing.
Schedule of Benefits		This is required to be submitted for review.
Summary of Benefits and Coverage (SBC)		This is required to be submitted as supporting documentation with the annual policy form filing.
Certificate of Actuarial Equivalence		This is required to be submitted when a benefit dollar limit has been substituted for a visit limit.
Benefit Limits	45 CFR 147.126	No Annual or Lifetime dollar limits.
No Misleading Language	631.20(2)(a)	Forms may not be inequitable, unfairly discriminatory, misleading, deceptive, obscure or encourage misrepresentation. Forms must be compliant with the uniform ACA application.

<b>Policy Requirements</b>		
<b>Face Page</b>	<b>Reference</b>	<b>Comments</b>
Corporate Legal Name	631.31 631.64	Full corporate name on face page of policy, full address somewhere in policy
Important Notice	Ins 3.31(3)(a)	Notice required on front of certificate, concerning statements made in the application.
Several Liability	631.31 631.41	If two or more insurers together issue the policy.
Claim Methodology Disclosure	Ins 3.60(5)	If insurer settles claim based on specific methodology, certificate must include notice on first page of certificate.
<b>General Contract</b>		
Entire Contract	631.11	Representations, warranties, and conditions.
Statement of Provisions	Ins 3.14(4)	Language required in certificate.
Termination	631.36(4) & (5) 632.79	60-day notice for certain nonrenewals, prior notice of termination. Enrollment in an ACA plan is subject to guarantee renewal. If a specific plan is not being offered at renewal, another similar plan must be offered.
Premium Increase	631.36(5)	60-day notice of premium increases greater than 25%. Rates must be set for entire plan year.
Incontestability	632.76	A policy is incontestable after 2 years, except for fraudulent misrepresentation.
Grace Period	632.78	Required grace period of 10 days for monthly, 31 days for all other policies.
Prohibited Provisions	632.75	Prohibition of exclusion from coverage of certain dependent children; Out-of-state service providers.
Prohibiting Refusal to Cover Services because Liability Policy May Cover	632.845	A policy may not refuse to cover health care services that are provided to an insured and for which there is coverage on the basis that there may be coverage for the services under a liability insurance policy.
Permitted Provisions	632.77	Misstatement of age; Limitations on payments; Facility of payment.
Restrictions on Health Care Services	632.87	A policy cannot deny benefits for services provided by a practitioner based on the grounds that the services weren't provided by a physician, unless the policy specifically excludes services by such practitioner.
Notice and Proof of Loss	631.81	Notice or proof of loss is furnished as soon as reasonably possible & within one year of time required by policy.
Limitation of Actions	631.83(1)(b)	Action must be commenced w/in 3 years of when proof of loss was required to be furnished. No provision may prescribe in what court action may be brought, nor provide that no action may be brought.
Subrogation	Case law	WI case law (see <u>Rimes v. State Farm Mutual Automobile Insurance Company</u> , 106 Wis. 2d 263) has established that the insurer's ability to recover is limited to the amount remaining after the insured has been "made whole" and there must be a positive statement to this effect in the policy.
Arbitration	631.20(1)(a) 631.85	A policy may contain provision for independent appraisal and compulsory arbitration

No Prior Authorization for Emergency Room Use	632.85	A plan may not require prior authorization for coverage of the emergency services.
Coverage of Drugs and Devices	632.853	If the policy covers health care expenses and certain prescription drugs or devices, it shall develop an appeal process for which a physician can request an exception.
Experimental Treatment	632.855	A policy that limits coverage of experimental treatment shall define the limitations in any agreement, policy, or certificate of coverage.
Chiropractic Services	632.87(3)	A policy must provide coverage of services received from a chiropractor.
Dentist Services	632.87(4)	If the policy covers treatment of a condition by another health care provider, it may not exclude coverage for treatment of a condition by a licensed dentist within the scope of the dentist's license.
Nurse Practitioner	632.87(5)	If the policy covers papanicolaou test, pelvic exams, and associated laboratory fees performed by a licensed physician, it must cover these services when performed by a nurse practitioner.
Complications of Pregnancy	Ins 6.55(4)(b)5	Complications of pregnancy must be treated the same as any other illness or sickness under the policy.
Handicapped Children	632.88	A policy that provides coverage for dependent children must provide an extension for handicapped children.
Adopted Children	632.896	A policy must provide coverage for adopted children or children placed for adoption with the insured.
<b>Eligibility</b>		
Covered Individuals	632.895 (5m) 632.896	Adopted child, grandchild, newborns.
Handicapped Children	632.88	A policy that provides that coverage of a dependent child of an insured terminates upon attainment of a limiting age shall provide that the age limitation shall provide that the age limitation may not operate to terminate coverage when the child meets the definition of handicapped child.
Coverage of Dependents	632.885	A policy must provide coverage, if requested by an applicant or insured, for an adult child if the child is under age 26 or if called to active duty while attending an institution of higher learning full-time regardless of age.
Coverage of Student on Medical Leave	632.895(15)	A policy that provides coverage for a person as a dependent because the person is a full-time student shall continue coverage for the person if, due to a medically necessary leave of absence, he or she ceases to be a full-time student.
Dependent Child	632.897(10) 632.75(3)	No policy that provides coverage to dependent children may deny eligibility or set a premium that is different based solely on the fact that the child does not reside with the group member or is dependent on another parent rather than the insured, or the proportion of the child's support.
Special Enrollment	632.746	Available in situations where other coverage has been lost either voluntarily or involuntarily. Also subject to ACA special enrollment guidelines.

<b>Mandatory Coverage</b>		
Oral and Injected Chemotherapy	632.867	A policy that covers injected or intravenous chemotherapy and oral chemotherapy may not require a higher copayment, deductible or coinsurance amount for oral chemotherapy than it requires for injected or intravenous chemotherapy.
Clinical Trials	632.87(6) PHSA section 2709	A policy may not deny a qualified individual participation in an approved clinical trial for the treatment of cancer or another life-threatening disease or condition, and may not deny coverage of routine costs in connection with participation in the trial. May require use of network provider.
Home Health Care	632.895(2) 9.38 (3)	If the policy covers expenses incurred for inpatient hospital expenses, it must cover a minimum of 40 home care visits per contract year.
Skilled Nursing Care	632.895(3) 9.38 (3)	If the policy provides coverage for hospital care, it must provide for 30 days of coverage per skilled nursing home confinement.
Kidney Disease Treatment	632.895(4) 9.38 (3)	If the policy provides hospital treatment coverage, it must provide an annual kidney disease benefit (i.e., dialysis, transplantation, donor related services).
Newborn Coverage	632.895(5) Ins 9.38 (3)	A policy must provide coverage of newborn of insured from moment of birth. A policy must cover preventive care and screening without cost sharing.
Congenital Defects & Birth Abnormalities	632.895(5) 9.38 (3)	A policy must treat as accident or sickness and cover functional repair or restoration.
Grandchildren Coverage	632.895(5m) 9.38 (3)	If the policy provides coverage for any child of the insured, it must provide the same coverage for all children of that child until that child is 18 years of age.
Diabetic Coverage	632.895(6) 9.38 (3)	If the policy provides coverage for diabetes, it must cover installation and use of infusion pump, all other equipment and supplies for diabetes, including insulin.
Maternity Coverage	632.895(7) 9.38 (3)	Coverage is required for emergency services with a non-participating provider within the last 30 days of the pregnancy. Coverage may not exclude surrogate pregnancy coverage for an insured.
Mammograms	632.895(8) 9.38 (3) 29 CFR 2590.715-2713	A policy must meet current USPSTF recommendations for screening mammographies beginning at age 40.
HIV Drugs	632.895(9) 9.38 (3)	If the policy provides coverage of prescription medication, it must provide coverage of drugs for the treatment of HIV.
Lead Poisoning Screening	632.895(10) 9.38 (3)	A policy must provide coverage for blood lead test for children under 6 years of age. Age limits without evidence-based justification may be considered discriminatory benefit design.
Temporomandibular Disorder (TMJ or TMD)	632.895(11) 9.38 (3)	A policy that provides coverage for diagnostic and surgical procedures for treatment of bone, joint, muscle or tissue shall provide coverage for diagnostic procedures and surgical or nonsurgical treatment for the correction of TMJ. A dollar limit may not be imposed. If a visit limit is imposed instead of a dollar limit, a Certificate of Actuarial Equivalence must be submitted.

Facility Charges and Anesthetics for Certain Dental Care	632.895(12) 9.38 (3)	A policy must provide coverage of charges and anesthetics provided in conjunction with dental care for children under age 5, individual with disability, or individual with medical condition that requires hospitalization or anesthesia for dental care. Age limits without evidence-based justification may be considered discriminatory benefit design.
Treatment for Autism Spectrum Disorders	632.895(12m) 9.38 (3)	A policy shall provide coverage for an insured of treatment for the mental health condition of autism spectrum disorder if the treatment is prescribed by a physician.
Breast Reconstruction	632.895(13) 9.38 (3)	If the policy provides coverage of a mastectomy, it must provide coverage or breast reconstruction of the affected tissue incident to a mastectomy.
Immunizations	632.895(14) 9.38 (3)	If the policy provides coverage for the dependent of an insured, it must provide coverage of appropriate and necessary immunizations for dependent children from birth to age 6. Age limits without evidenced-based justification may be considered discriminatory benefit design. USPSTF guidelines provide that specific immunizations for children under age 18 are not subject to cost-sharing.
Dependent Student Medical Leave	632.895(15) 9.38 (3)	A policy must continue to provide coverage to a dependent who ceases to be full time student due to medically necessary medical leave.
Hearing Aids, Cochlear Implants, and Related Treatment for Infants and Children	632.895(16) 9.38 (3)	A policy shall provide coverage of the cost of hearing aids and cochlear implants and treatment that is prescribed by a physician or by an audiologist for a child covered under the policy or plan who is under 18 years of age and who is certified as deaf or hearing impaired. Coverage for BAHA shall be provided when the criteria outlined in the benchmark plan is met. Age limits without evidence-based justification may be considered discriminatory benefit design.
Colorectal Cancer Screening	632.895(16m) 9.38 (3)	A policy that provides coverage of any diagnostic or surgical procedures shall provide coverage of colorectal cancer examinations, laboratory tests, anesthesia, and prep medications that are prescribed and integral to a preventative screening.
Contraceptives and Services	632.895(17) 9.38 (3)	A policy that provides coverage of out-patient health care services, preventive treatments and services, or prescription drugs and devices shall provide coverage for contraceptives and medical services as specified, including OTC methods that are both FDA-approved and prescribed for a woman by her healthcare provider. Coverage is preventive and not subject to cost-sharing. This includes brand name contraceptives if a generic equivalent is not available.
Mental & Nervous Disorders & AODA	632.89 Ins 3.37(5)	A policy must provide inpatient, outpatient, and transitional treatment for alcoholism, drug abuse, and mental/nervous disorders. Coverage of licensed mental health professionals includes clinical social worker, marriage and family therapist or professional counselor, and of licensed psychologists. Policy must indicate types of transitional treatment programs and services covered. Mental health and substance use disorder services are an essential health benefit (EHB).

Grievance Procedure	632.83 Ins 18	<a href="http://oci.wi.gov/bulletin/0402iro.htm">BULLETIN April 26, 2002 http://oci.wi.gov/bulletin/0402iro.htm</a>
Independent Review Procedure	632.835 Ins 18	A policy must include a description of its independent review process in policies and certificates. BULLETIN December 16, 2011, <a href="http://oci.wi.gov/bulletin/1211iro.htm">http://oci.wi.gov/bulletin/1211iro.htm</a> A policy must follow either the HHS or DOL independent review process, or the OPM process for multi-state plans.
Notice of Right to File a Complaint	631.28 Ins 6.85(4)	Notice described under Ins 6.85, Appendix 1 or 2, Wis. Adm. Code.
<b>Women's Health Benefits</b>		
Maternity Services	609.05 (2) 45 CFR 147.138	Coverage is required for emergency services with a non-participating provider that is no more restrictive than coverage of emergency services delivered by participating providers. HMOs may limit coverage of routine delivery within the last 30 days of the pregnancy to only participating provider. Coverage may not exclude surrogate pregnancy coverage for an insured.
Breast Pumps	PHSA section 2713	Coverage required for breastfeeding equipment and support for the duration of breastfeeding based on HRSA guidelines.
Genetic Testing/BRCA	PHSA section 2713	Coverage required for women with positive screening results or women with a personal history of cancer based on USPSTF recommendations and HRSA guidelines.
<b>Other Benefits</b>		
Accidental Dental	45 CFR 147.126	Included as benefit in WI EHB Benchmark plan. Coverage cannot impose a dollar limit.
Tobacco Cessation	PHSA section 2713	Coverage of evidence based tobacco-cessation services with no cost-sharing, including FDA approved smoking cessation drugs with a prescription.
Transplants	45 CFR 156.125	For transplants included in WI EHB Benchmark plan, coverage cannot require a 90 day waiting period.
Abortion	632.8985	A QHP Marketplace policy must include an exclusion for elective abortions, except to save the life of a woman, or if pregnancy is the result of rape or incest.
Over-the-Counter Drugs	PHSA section 2713	Required coverage for some OTC drugs based on USPSTF recommendations
Gender Identity	45 CFR 156.200(e) PHSA section 2713	Discrimination based on gender identity prohibited. Coverage for sex-specific recommended preventive services without cost-sharing may not be limited by an individual's sex assigned at birth, gender identity or recorded gender.
<b>Definitions</b>		
Pediatric Services	Final HHS Notice of Benefit and Payment parameters for 2016	If definition of a pediatric service includes an age limit, must provide services for individuals through age 18.
Prescription Drug Deductible	PHSA section 2707(b) SBC	A policy must define if the deductible is or is not included in the medical deductible, and deductible may not exceed out-of-pocket limits in section 1302(c)(1) ACA.
Habilitative	ACA Uniform Glossary of Health Coverage and Medical Terms	Health care services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology

		and other services for people with disabilities in a variety of inpatient and/or outpatient settings.
Rehabilitative	ACA Uniform Glossary of Health Coverage and Medical Terms	Health care services that help a person keep, get back or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt or disabled. These services may include physical and occupational therapy, speech-language pathology and psychiatric rehabilitation services in a variety and/or outpatient settings.
<b>SMALL GROUP PLANS</b>		
<b>Policy Requirements</b>	<b>Reference</b>	<b>Comments</b>
Small Employer Group Requirements	635.02	2-50 employees. BULLETIN October 2, 1997 <a href="http://oci.wi.gov/bulletin/1097bul.htm#smallemp">http://oci.wi.gov/bulletin/1097bul.htm#smallemp</a>
Participation Requirements	Ins 8.46 45 CFR 156.285(e) 45 CFR 147.104(b)(1)(i)(b)	An insurer may establish participation requirements on a small group, unless it is during the SHOP open enrollment period.
Non-renewal or termination based on participation requirements	Ins 8.54(4) 45 CFR 156.285(e) 45 CFR 147.104(b)(1)(i)(b)	Insurer must give policyholder an additional 60 days to increase participation to required number. A SHOP plan cannot require participation requirements during open enrollment. Upon renewal in 12 months, if an employer chooses to enroll in the same health plan, they'll need to meet SHOP's minimum participation rate.
Late Enrollee	632.745(18)&(27) 45 CFR 147.116	Waiting period cannot exceed 90 days under the ACA.
<b>DEFINED NETWORK PLANS</b>		
<b>Policy Requirements</b>	<b>Reference</b>	<b>Comments</b>
Disclosure of Restrictions	Ins 9.38(2)	Emergency & urgent care, primary & urgent provider, changing providers, out-of-pocket costs, dependents not residing in service area.
<b>Definitions</b>		
Defined Network Plans and PPPs	Ins 9.38(1)	Geographic Service Area, Emergency Care, Urgent Care, Out-of-Area Service, Dependent, Primary Provider.
Participating	609.01(3m)	Physician or other provider under contract with the health plan.
Primary Provider and PCP	609.01(5)	Participating primary care physician or other participating provider authorized by the health plan.
<b>Benefit Description</b>		
Designation of Primary Provider	609.05(2)	Requirements for designating primary care provider (PCP) and for obtaining services from PCP when reasonably possible. Also subject to the ACA definition of PCP and referral requirements.
Differential between PPO and Non-PPO Providers	Ins 9.25(2)	Disclosure requirements regarding differentials and cost-sharing.
No Referrals for Ob/Gyn Services	609.22(4m)	Written statement in policy or certificate.
Referrals	609.05(3) Ins 9.38 (4)(a)	Requirements for obtaining referral from PCP.

Standing Referral	609.22(4) Ins 9.38(4)(a)	If the policy requires referrals, must have process for offering standing referral to specialist.
Second Opinions	609.22(5) Ins 9.38(4)(b)	May be limited to another participating provider.
Emergency Care	609.22(6) Ins 9.38(4)(c) PHSA section 2719A	May require notification, but not less than 48 hours after receiving services. Emergency services are an essential health benefit (EHB). May not impose any copayment or coinsurance requirement that is higher than the copayment or coinsurance requirement that would apply if the services were provided in network.
Urgent Care	PHSA section 2719 SBC	The required claims and appeals process addresses claims involving urgent care. Urgent care services are a separate benefit from ER services.
Continuity of Care	609.24	Provision regarding continuity of care for provider that has left the plan.
Out-of-Pocket Expenses	Ins 9.38(2)(d)	Description of restricted network provisions, including coinsurance, copayments, and deductibles when non-network providers are utilized.
Court Ordered Mental Health Services	609.65	The policy must provide coverage for emergency care/detention.
Dependent Student Mental Health	609.655	Coverage of outpatient nervous and mental disorders if student attending school located within state but outside geographic service area, if services would be covered within geographic service area.
Disenrollment	Ins 9.39	Only applies for nonpayment of premium and termination for cause. May not include termination because the insured is abusive to the provider.
Quality Assurance Plan	Ins 9.40(7)	Description and statement of patient rights & responsibilities in certificate or enrollment materials.
<b>APPLICATION &amp; ENROLLMENT FORM</b>		
<b>Requirements</b>	<b>Reference</b>	<b>Comments</b>
Corporate Name	631.31 631.64	Include legal name of company on application.

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