Form Filing Checklist - Individual Health- Comprehensive

TOIs: HOrg02I Individual Health Organizations–Health Maintenance (HMO)
H16I Individual Health–Major Medical
H22.000 Student Health Insurance

DISCLAIMER

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 an interpretation of 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 a Wisconsin administrative code [regulation]) or contain CFR (which is a federal regulation).

General Requirements for SERFF Filings		
Filing Requirements	**Reference**	**General Information**
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.
Transmittal Document	Ins 6.05(4)(a)1	SERFF incorporates the required transmittal documents. The "Help" link in SERFF provides access to instructions and tutorials.
Filing Description	Ins 6.05(4)(a)3a	Explain the purpose of the form filing. Indicate if the filing is new, or a revision of a previously filed form. If related to a previously filed form, provide a brief explanation of changes and attach a red-lined copy under the Supporting Documentation Tab.
Certificate of Compliance and Readability	Ins 6.05(4)(a)2 Ins 6.05 Appendix A Ins 6.07(4)	Include information identified in the SERFF Submission Requirements and instructions. Under the Form Schedule Tab, provide a Readability score for each form filed.
Statement of Variability	Ins 6.05(4)(a)5	If a form contains variable material or language, submit as supporting documentation, a detailed description identifying the variable data and all variable ranges or options.
Pediatric Dental Benefit Disclosure		BULLETIN April 2, 2013, http://oci.wi.gov/bulletin/0413peddental.htm
Drug Formulary		Required to be submitted as supporting documentation with the annual policy form filing.
Redlined Copy		Required to be submitted as supporting documentation, highlighting changes to a similar and previously filed form.
Schedule of Benefits		Required to be submitted.
Summary of Benefits and Coverage (SBC)		Required to be submitted as supporting documentation with the annual policy form filing.
Certificate of Actuarial Equivalence		Required to be submitted with annual policy form filing when a benefit dollar limit has been substituted for a visit limit.

Policy Requirements		
Face Page	**Reference**	**Additional Information**
Several Liability Clause	631.31 631.41	If two or more insurers together issue the policy, include explanation of several liability.

Face Page	Reference	Additional Information
Corporate Legal Name	631.31 631.64	Show full corporate name on face page of policy and full address of its home office somewhere in policy.
Right to Return Disclosure	631.31 632.73 Ins 3.13(2)(j)2&3	Include information about the 10 day "free look" period on face page of policy or conspicuously attached to the first page.
Renewal Provision	Ins 3.13(2) 45 CFR § 148.122	Explain conditions under which the policy may be renewed. Enrollment in an ACA plan is subject to guaranteed renewability.
Important Notice Concerning Statements in the Application for Your Insurance	Ins 3.28(5)(d)	Notice required on face page of policy, concerning statements made in the application.
Claim Methodology Disclosure	Ins 3.60(5)	Explain method for settling claims.
General Contract	**Reference**	**Additional Information**
Entire Contract	631.11	A policy shall state what forms or documents constitute the entire contract.
Notice of Right to File a Complaint	631.28 Ins 6.85(4)	Notice described under Ins 6.85, Appendix 2, Wis. Adm. Code.
Rescission	631.36 (2) 45 CFR 147.128	Rescission language must clearly state that the fraud must be intentional and involve a material fact.
Termination Notice	631.36(4)& (5)	60-day notice for certain nonrenewals, and prior notice of termination. If a specific plan is not being offered at renewal, another similar plan must be offered.
Premium Increase Notice	631.36(5)	60-day notice of premium increases greater than 25%. Rates must be set for entire benefit year.
Notice and Proof of Loss	631.81(1)	Notice or proof of loss is furnished as soon as reasonably possible and within one year of time required by policy.
Limitation of Actions	631.83(1)(b) 631.83 (3)	Action must be commenced within 3 years of when proof of loss was required to be furnished. Provisions may not prescribe in which court an action may be brought, nor provide that no action may be brought.
Arbitration Clause	631.85	A policy may contain provision for independent appraisal and compulsory arbitration, subject to the provisions of 631.20, Wis. Stat.
Reinstatement Provision	632.74	Required reinstatement provision if policy terminates for nonpayment of premium [waiting periods for illness not allowed].
Prohibited Provisions	632.75(3)&(4)	Prohibition of exclusion from coverage of certain dependent children; out-of-state service providers.
Incontestability	632.76(1)	A policy is incontestable after 2 years, except for fraudulent misrepresentation.
Permitted Provisions Requirements	632.77	Misstatement of age; Limitations on payments; Facility of payment.
Grace Period	632.78	Required grace period of 10 days for monthly, 31 days for all other policies, unless member receives APTC and has paid one full month's premium, then grace period is 90 days.
Grievance Procedure	632.83 Ins 18	BULLETIN April 26, 2002 http://oci.wi.gov/bulletin/0402iro.htm May not require insured to exhaust grievance process prior to filing legal action.
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 http://oci.wi.gov/bulletin/1211iro.htm A policy must follow either the HHS or DOL independent review process, or the OPM process for multi-state plans.

General Contract	Reference	Additional Information
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.
Handicapped Children	632.88	A policy that provides coverage for dependent children must provide an extension for handicapped children.
Coverage of Dependents	632.885	A policy shall 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.
Grandchildren Coverage	632.895(5m) Ins 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 covered child until that child is 18 years of age.
Eligible Children	632.895 (5m) 632.896 632.897(10)	Eligible children; adopted child, grandchild, newborn. A policy may not exclude eligible children from coverage based on residence, support provided by insured parent, tax exemption status or marital status of parents.
Adopted Children	632.896	A policy must provide coverage for adopted children or children placed for adoption with the insured.
Subrogation	Case Law	Wisconsin case law (see Rimes v. State Farm Mutual Automobile Insurance Company, 106 Wis. 2d 263) has established that the insurer's recovery rights are 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.
Health Benefits/Services	**Reference**	**Additional Information**
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.
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.
Restrictions on HealthCare 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.
Chiropractic Services	632.87(3) 632.875	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) 632.895(8)(a) 3	A policy that covers mammograms, papanicolaou tests, pelvic exams, and associated laboratory fees performed by a licensed physician, must cover these services when performed by a nurse practitioner.

Health Benefits/Services	Reference	Additional Information
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(1) & (2)	If the policy covers expenses incurred for inpatient hospital expenses, it must cover a minimum of 40 home care visits per year. ACA plans must cover minimum depicted in WI Benchmark Plan, (60 home care visits).
Skilled Nursing Care	632.895(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)	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 3.38	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)(b)	A policy must treat as accident or sickness and cover functional repair or restoration.
Diabetic Coverage	632.895(6)	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 or any other prescription medication, used in the treatment of diabetes, and coverage of diabetic self-management education programs. Insulin pumps can be limited to no less than one pump per year.
Mammograms	632.895(8) 29 CFR 2590.715-2713	A policy must meet current USPSTF recommendations for screening mammography beginning at age 40.
HIV Drugs	632.895(9)	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)	A policy must provide coverage for blood lead test for children under 6 years of age. State mandates that contain age distinctions do not violate Section 1557. [Preamble to Section 1557, under § 92.101 of subpart B.]
Temporomandibular Disorder (TMJ or TMD)	632.895(11)	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)	A policy must provide coverage of charges and anesthetics provided in conjunction with dental care for a child under age 5, individual with disability, or individual with medical condition that requires hospitalization or anesthesia for dental care. State mandates that contain age distinctions do not violate Section 1557. [Preamble to Section 1557, under § 92.101 of subpart B.]
Treatment for Autism Spectrum Disorders	632.895(12m) Ins 3.36	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.

Health Benefits/Services	Reference	Additional Information
Breast Reconstruction	632.895(13)	A policy that covers a mastectomy shall provide coverage for breast reconstruction of the affected tissue incident to a mastectomy.
Immunizations	632.895(14)	A policy must provide coverage of appropriate and necessary immunizations for dependent children from birth to age 6. USPSTF guidelines provide that specific immunizations for children under age 18 are preventive and not subject to cost-sharing. State mandates that contain age distinctions do not violate Section 1557. [Preamble to Section 1557, under § 92.101 of subpart B.]
Dependent Student Medical Leave	632.895(15)	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)	A policy must 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 is required when the criteria outlined in the benchmark plan is met. State mandates that contain age distinctions do not violate Section 1557. [Preamble to Section 1557, under § 92.101 of subpart B.] Adult hearing aid coverage is an essential health benefit in the Benchmark plan.
Colorectal Cancer Screening	632.895(16m) Ins 3.35	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.
Prescription Eye Drops	632.895(16t)	A policy that provides coverage of prescription eye drops shall cover a refill of the prescription eye drops when requested when 75% or more of the days have elapsed from the later of original date prescription was distributed or date which most recent refill was distributed.
Contraceptives and Services	632.895(17)	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.
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.
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.
Disclosure of Mandated Benefits	Ins 9.38(3)	Clear disclosure of all benefit mandates outlined in Wisconsin statutes.
Other Benefits	**Reference**	**Additional Information**
Mental Health and Substance Use Disorder Services	42 U.S. Code § 18022 29 CFR 2590.712 (c)(4)(i)	Mental health and substance use disorder services are an essential health benefit (EHB) and required coverage for some individual health policies. Mental Health Parity required. Medical/Surgical not to be treated any different from Mental Health/Substance Abuse. Limitations or exclusions are to be based on clinical efficacy.
Benefit Limits	45 CFR 147.126	No Annual or Lifetime dollar limits on essential health benefits.
Accidental Dental	45 CFR 147.126	Treated as essential health benefit in WI Benchmark plan. Dollar limit cannot be imposed.

Other Benefits	Reference	Additional Information
Maternity Services	45 CFR 147.138 609.05 (2)	Coverage is required for Maternity Services. Coverage 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.
Transplants	45 CFR 156.125	For transplants included in WI EHB Benchmark plan, coverage cannot require a 90-day waiting period.
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.
Breast Pumps	PHSA section 2713	Coverage required for breastfeeding equipment and support for the duration of breastfeeding based on HSRA 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 HSRA guidelines.
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.
Over-the-counter Drugs	PHSA section 2713	Required coverage for some OTC drugs based on USPSTF recommendations.
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.
Definitions	**Reference**	**Additional Information**
Habilitative	ACA Uniform Glossary of Health Coverage and Medical Terms 45 CFR 156.115(a)(5) (ii) & (iii)	Definition: 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. Do not impose limits on habilitative less favorable than rehabilitative. Do not impose combined limits on habilitative services and rehabilitative services/devices.
Rehabilitative	ACA Uniform Glossary of Health Coverage and Medical Terms 45 CFR 156.115(a)(5) (ii) & (iii)	Definition: 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. Do not impose limits on habilitative less favorable than rehabilitative. Do not impose combined limits on habilitative services/devices and rehabilitative services/devices.
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	Final HHS Notice of Benefit and Payment Parameters for 2016	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.

Defined Network Plans		
Policy Requirements	**Reference**	**Additional Information**
Designation of Primary Care Provider	609.01 609.05(2)	May have requirements for designating primary care provider (PCP) and for obtaining services from PCP when reasonably possible. Subject to the ACA definition of PCP and referral requirements**.**
Referrals Standing Referrals	609.05 (3) 609.22 (4)	Requirement for obtaining referral from Primary Care Physician. If the policy requires referrals, must have process for offering standing referral to specialist.
No Referrals for Ob/Gyn Services	609.22(4m)	Written statement in policy or certificate.
Second Opinions	609.22(5) 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.
Continuity of Care	609.24	Provision to provide access and continuity of care when provider has left the plan.
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.
Preferred Provider Plans (PPP) Notice Requirements	Ins 9.25(1), (2) (5)	Notice requirements applicable to PPPs related to cost-sharing differences applied to participating and non-participating providers for same services.
Preferred Provider Plans (PPP) Coinsurance, Deductible, Copayment Differentials	Ins 9.27 (1), (2) (3)	Notice under Ins 9.25 (5) may not be required based on cost-sharing differentials for a participating and non-participating provider.
Plan Definitions	Ins 9.38(1)	Geographic Service Area, Emergency Care, Urgent Care, Out-of-Area Service, Dependent, Primary Provider
Disclosure of Exclusions, Limitations and Exceptions	Ins 9.38(2)	Emergency & urgent care, selection of primary or referral providers, changing providers, out-of-pocket costs, dependents not residing in service area.
Disclosure of Procedures and Emergency Care Notification	Ins 9.38(4)	Procedures for standing referral if policy requires a referral, emergency care notification. The policy cannot require emergency care notification less than 48 hours after receiving services or before it is medically feasible.
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.

Application		
Requirements	**Reference**	**Additional Information**
Corporate Name	631.31	Include legal name of company on application