GOVERNMENT OF PUERTO RICO
OFFICE OF THE COMMISSIONER OF INSURANCE
PUERTO RICO FORM FILING CHECK LIST
SMALL GROUP MARKET

COMPANY: _____

FORM NUMBER: _____

SERFF TRACKING NUMBER: _____

TYPE OF INSURANCE (TOI) _____

ATTACHMENT 7B

REVISED 02/2022

SUBJECT	REGULATORY REFERENCE	COMMENTS	Please specify location (Form/Page/Paragraph/ Other) of complying provision/language * or attach explanation for a N/A response **	FOR OFFICIAL USE ONLY
Licensing	§ 303	The carrier[1] is licensed to transact disability insurance business or is authorized as a Health Service Organization in Puerto Rico.		
Final Form	§ 1111	The form(s) is(are) in the final format in which it(they) will be issued. No draft, highlighted, redline or watermark is(are) included in the Form Schedule Tab.	☐ Yes ☐ No	
Filings made on behalf of the carrier by another party	Circular Letter CC-2015-1870-AV/AS	A letter authorizing the third party to act on behalf of the carrier is included in the Supporting Documentation Tab and provides the following information: (a) on carrier's letterhead or include the carrier name in the "Re" line of the authorization; (b) specifically addressed to the Office of the Commissioner of Insurance of Puerto Rico; (c) properly executed by an authorized officer of the carrier; (d) dated; and either (e) specific to the file submitted for approval by including form number(s); or (ii) generally applicable to all contract forms filed on behalf of the carrier as long as a copy of such authorization is included in each submission.		
Cover Letter-Resubmissions	Rule XXIV	If the form has been previously submitted to the OCI and the file was closed or withdrawn, any resubmission's cover letter must reference the SERFF tracking number of the previously closed file **and address all outstanding issues in the new cover letter.** The new cover letter shall include a reference where each objection has been addressed within the forms	☐ Yes ☐ No	
Cover Letter		If the insurer or health services organization intends to subscribe the health plan by electronic means, it must mention it in the cover letter.	☐ Yes ☐ N/A	Updated
Cover Letter		In relation to metallic plans, the cover letter indicate if the carrier will be offering these forms outside the open enrollment period, with or without waiting period.	☐ Yes ☐ No	

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Cover Letter	Circular Letter CC-2015-1870-AV/AS Rule XXIV	The filing include a cover letter under the Supporting Documentation Tab in SERFF, which includes: a. A detailed explanation as to the purpose of the filing, and the intended use for each submitted form. b. Disclose if form is new or replacement. If it is an amendment, endorsement or rider, the contract it will go with. c. The signature of a representative of the carrier, authorized to submit forms for filing or approval for the carrier. d. A description of any innovative or unique features of each form. e. In the "Re" section, the identification form number of all the forms submitted for approval are displayed with the same form number that appears in the lower left corner of the form. **This means that if the word "Form" does not appear in the lower left corner then it should not be part of the Form Number on the cover letter.** f. The name of the carrier presenting the submission and is signed by a representative of the carrier authorized to submit forms for filing or approval. g. Explanation on whether or not the form is replacing a previously submitted form. h. If the form replaces a previously approved form, the cover letter identify and explain the material differences or changes made to the form. i. indicate the SERFF tracking number of the filing where the rates applicable to the form(s) were submitted.	☐ Yes ☐ No	
Variability (bracketed language)	§ 1111 § 1112	Forms with variable bracketed information **must include all the possible language that might be placed within the brackets**. The use of too many variables will result in filing disapproval, as OCI staff may not be able to determine whether the filing is compliant with Puerto Rico laws and regulations. The submission must include a separate detailed Memorandum of Variable Material to explain any variable material in the form(s). In order to be approved, any form will need to be furnished accompanied by the intended alternate, replacement, and/or additional language. The use of these brackets, within the approved form, will be limited to the alternatives filed by the carrier.	☐ Yes ☐ N/A	
Variable Language Blank pages	§ 1111	Brackets around an entire page constitute a "blank" or generic form – not permitted		
Red-lined, highlighted, draft or watermark copies		Redline, highlighted, draft or watermark copies are not approvable and must be placed on the SERFF Supporting Documentation Tab.	☐ Yes ☐ N/A	

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Amendments or Endorsements	§ 1118	The contract may not be modified unless the modification is in writing and agreed to by the party against whose interest the modification operates.		
Rider a Rider	§ 1112	Companies may not “rider a rider”, "endorse and endorsement" or "amend an amendment".	☐ Yes ☐ N/A	
Form Number		A form identification number (consisting of numerical digits, letters, or both) appears in the lower left-hand corner of the cover page and in all the pages of the form(s). The form identification number is the same in all pages.	☐ Yes ☐ No	
Cover Page		The licensed Puerto Rico carrier’s name appears on the cover page of the form(s), as well as the cover page of each rider, amendment, application and endorsement form. Full street address of the carrier’s Home Office (bracketed or underlined to reflect possible future changes) for disclosure purposes appears on the cover page or back page of the form. A brief description of the contract (e.g., “individual metallic plan platinum” "small group metallic plan gold") appears on the form cover page. The signature of at least one officer of the carrier appears in the first page, in order to execute the contract. Signatures appearing on contract form(s) can be bracketed to denote variability.	☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No	
Unfair, Misleading, Deceptive Provisions.		Form(s) does(do) not include inequitable, unfairly discriminatory, misleading, deceptive, obscure, unfair, encourage misrepresentation, or not in the public interest provisions. Form(s) does(do) not contain inconsistent, ambiguous or misleading clauses, or contain exceptions and conditions that unreasonably affect the benefits purported to be provided in the coverage.	☐ Yes ☐ No	
CHAPTER 17 OF THE INSURANCE CODE OF PUERTO RICO (Insurance Code)				
Group Status	§ 1701(3)	No group disability insurance policy shall be issued for delivery in Puerto Rico, unless it is in agreement with one of the descriptions contained in Section 14.010. **The Ssubmission letter should include a statement that the policy or contract form will be sold to a group specified in the Insurance Code.**	☐ Yes ☐ No	
Grace Period Provision	§ 1703	This provision must be included and must be no less favorable to the insured than the statutory provision.		

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Certificates	§ 1706	The insurer shall issue to the policyholder, for delivery to each insured person, an individual certificate stating the protection which the insured person, who will be paid the insurance benefits and the rights and conditions established in subsections (1), (2), (3) and (4) of § 1707 of this title.		
Conversion – Right to a New Contract After Termination	§ 1707	This provision must be included and must be no less favorable to the insured than the statutory provision.		
HEALTH INSURANCE CODE OF PUERTO RICO (Health Code)				
Definitions	§ 2.030 § 4.030 §10.030 § 22.030 § 24.030 § 28.030 § 52.030 § 72.030 § 48.020	Definitions included in the policy or contract form must comply with Sections 2.030, 4.030, 8.030, 22.030, 24.030, 28.030, 52.030 and 72.030 of the Health Insurance Code.	☐ Yes ☐ No	
Dependents coverage	Sections 2.03(G)	If dependent coverage is selected by the group, this policy or contract form provides coverage of children until the age of 26. Conditions limiting the dependent coverage based upon financial dependency, marital status, enrollment in school, residency or other factors are not applicable. Also, the definition of "Dependent" must comply with Sections 2.030(G of the Health Code.		
Prohibition on Annual and Lifetime Dollar Limits	§ 2.050 (A)(1) § 2.050 (A)(2)	This policy or contract form must not include annual or lifetime limits on essential health benefits.		
Preventive Services	§ 2.050(C)	This policy or contract form provides coverage for the following preventive care and screenings for children and adults with no cost-sharing:		
Emergency Services	§ 2.050(F)	This policy or contract form provides coverage for the treatment of an emergency condition in a hospital: *Without the need for any prior authorization; * Regardless of whether the provider is a participating provider; * Without imposing any administrative requirement or limitation that is more restrictive than that required for participating provider services, and at the in-network cost-sharing level.		
Designation of Primary Care Provider and access to pediatricians	Chapter 2 / Health Insurance Code § 2.050(G)	If the policy or contract form requires the designation of a primary care provider, the form permits the designation of a physician who specializes in pediatrics, when the enrollee is eighteen (18) years old or less, as the child's primary care provider, provided that such provider participates in the network of participating providers of the health plan. *(Only applicable to coverage managed through referrals and the designation of primary care provider is required)*		

Updated

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Designation of Primary Care Provider and Direct Access to OB/GYN Services	§ 2.050(H)	If this policy or contract form requires the designation of a primary care provider, it must not require prior authorization or referral to obtain obstetrical and gynecological care provided by participating providers. *(Only applicable to coverage managed through referrals and the designation of primary care provider is applicable)*		
Pre-existing Conditions	§ 2.050 (I) § 8.070(C)(1)	No group health plan shall deny, exclude or limit the benefits of an enrollee based on preexisting conditions, regardless of the age of the enrollee.		
Rescission	§ 2.050(J)	Coverage may only be rescinded or cancelled for fraud or intentional misrepresentation of material fact. Notification must be given to the insured (30) calendar days prior to cancellation. Recovery of the provided services cost is not allowed.		
Prescription drugs	§ 4.060(A)(1)(b)	Information indicating which prescription drugs, if any, are subject to a management procedure that has been developed and maintained is disclosed in the contract.		
Changes to the formulary	§ 4.060(A)(2)	The contract shall establish that changes in the formulary or other prescription drug management process during the term of the contract shall only be made if such change is being made for safety reasons, because the prescription drug cannot be supplied or has been withdrawn from the market by the drug's manufacturer, or if such change entails the inclusion of prescription drugs in the formulary. To such effects, the carrier shall provide or entrust a third party to provide notice of that change to all enrollees and pharmacies not later than the effective date of the change.		
Formulary Exceptions	§ 4.070	This policy or contract form must provide for a formulary exception process for prescription drugs not on the insurer's formulary. The contract must include the Medical Exceptions Approval Process Requirements and Procedures in accordance to Section 4.070. **The language of this section must be included in the contract in the same format and order established in Section 4.070.**		
Disclosure	§ 4.100	The contract, certificate, membership booklet, outline of coverage, evidence of coverage, or any other document provided to an enrollee shall include the disclosures required in Section 4.100.		
Maintenance medications	§ 4.120	The policy or contract form shall establish that for insured's that so require, insofar as it does not jeopardize his or her health, and at the discretion of the healthcare provider, the healthcare provider may prescribe refills for maintenance drugs up to a term that shall not exceed one hundred eighty (180) days, subject to the limitations of the health plan's coverage.		

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Waiting period	§ 8.030(O)	Health plans with waiting periods must define the term 'Waiting Period' as the period of time that must pass before coverage for a covered person or enrollee who is otherwise eligible to enroll under the terms of a health plan can become effective. However, emergency room services will not have a waiting period and the waiting period for preventive services may not exceed thirty (30) days.		
Waiting period	§ 8.070(C)(3)	Health plans of small groups and small group health plans for bona fide associations may not have a waiting period that exceeds (90) days. However, emergency room services will not have a waiting period and the waiting period for preventive services may not exceed (30) days. In the case of a health plan that contains a waiting period, the carrier must reduce it if the enrollee has a creditable coverage, and it has ended on a date not before(90) days prior to the date of enrollment to the new health plan. The reduction provided shall be for the entire period of creditable coverage.		
Renewal	§ 8.060	The policy or contract form provides that except as specified in § 8.060, the insurer must renew or continue in force such coverage at the option of the group.	☐ Yes ☐ No	
Eligibility	§ 8.070(C)(2)	A carrier may not establish eligibility or renewal rules in a health plan through which it is discriminated by reason of a factor related to the health of the enrollee. Eligibility rules will be understood as those related to the following: the subscription in a health plan, the rate, the effective date of the coverage, waiting periods, late enrollees, special subscription periods, election of benefits, inclusion of dependents or cover termination, among others.	☐ Yes ☐ No	
Pregnancy	§ 8.070(C)(4)	Health plans for small groups or bona fides associations will not impose any exclusion due to pregnancy.		
Enrollment Period	§ 8.070(C)(5)	Carriers will allow late enrollees to subscribe according to the terms of the health plan during a special subscription period if: (a) The late enrollee was covered by another health plan when the health plan for PYMES or small groups of bona fide associations was offered, including a health plan in accordance with the provisions of COBRA; (b) The other health plan held by the late enrollee was terminated in accordance with the eligibility requirements of said health plan, which include separation, divorce, death, termination of employment, or reduction in the number of hours of employment or employer contributions to the other coverage have been terminated; and (c) The late enrollee requests to take advantage of the health plan of employers of PYMES or small groups of the bona fide association, no later than (30) days from the expiration date of the other health plan.		

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Enrollment Period	§ 8.070(C)(6)	Any carrier providing a health plan to employers of PYMES or small groups of the bona fides associations will establish a special period for the enrollment of dependents, during which the dependent and the eligible employee or member of the bona fide association, if not subscribed by another way, can enroll to the health plan, in the case of birth, adoption of a child, adjudication of custody or guardianship, or in the case of marriage. The special enrollment period shall be a period of no less than (30) days and shall begin on the later date of the following: (a) The date on which the health plan for dependents becomes available; or (b) The date of marriage, birth, adoption or adjudication of custody or guardianship. If the eligible employee or member of the bona fide association enrolls the dependent during the first (30) days of the special enrollment period, the effective date of the health plan shall be as follows: (i) In the case of marriage, the first day of the month beginning after the date on which the request for enrollment was received; (ii) In the case of a dependent's birth, as of the date of birth; and (iii) In the case of a dependent's adoption award of custody or guardianship, the date of the adoption or award.		
Minimum participation requirements - PYMES	§ 8.070(C)(7)	PYMES employer carriers shall not require a minimum participation level greater than: (a) (100%) of eligible employees working for employers of three (3) or less employees; and (b) (75%) of eligible employees working for employers with more than four (4) employees. In applying minimum participation requirements with respect to a PYMES employer, an issuer shall not consider employees or dependents who have creditable coverage in determining whether the applicable percentage of participation is met. Individuals covered under a health plan pursuant to continuation provisions of COBRA shall not be considered. Issuers shall not increase any requirement for minimum employee participation or modify any requirement for minimum employer contribution applicable to a PYMES employer at any time after such employer has been accepted for the health plan. *(Only applicable to PYMES)*		

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Minimum participation requirements - Bonafide Associations	§ 8.070(C)(8)	The small group health plans of the bona fide associations will be subscribed through a group health plan issued by carrier, in favor of the bona fide association, subject to compliance with each of the following requirements: (a) All members of the bona fide association, employees of the member employer and their dependents shall be eligible for health plan, regardless of the existence of any factor related to the state of health; (b) The premium to be charged shall be paid by the members of the enrolled bona fide association; (c) In order to issue the coverage, the carrier will not require a level of participation that is greater than a minimum of (25) members of the bona fide association's health plan; (d) A bona fide association may negotiate and contract the group health plan for the benefit of the members of said association with one or more carriers. For the bona fide association to contract with more than one carrier, each member of the bona fide association shall have the right to select, among the available group health plans, the one that offers the premiums, coverage and benefits that best fit their needs. (e) Two or more small groups of bona fide associations may be grouped for purposes of negotiating services for their members. If the grouping exceeds the number of (50) members, the grouped bona fide associations will be considered as a large group. (f) No carrier may enroll to health plans for small groups or large groups of bona fide associations that do not meet all the criteria established in the definition of the Bona Fide Association. Nor can any entity that does not meet the criteria established in the definition of bona fide association be able to process in any way health plans of groups of bona fide associations to its members. *(Only applicable to small group health plans for bonafide associations)*		
Eligibility	§ 8.070(C)(9)	The carrier offering a health plan to an employer of PYMES or small groups of bona fide associations will offer it to all eligible employees of said employer, members of said association and their dependents. The carrier will not limit the health plan only to certain eligible employees, members of the bona fide association or dependents of the group.		
Enrollment	§ 8.070(C)(10)	Carriers of employers of PYMES or of the bona fide associations will not establish any restriction regarding the enrollment in the health plan of the eligible employees or their dependents that is related to their health condition.		
Certification of Creditable Coverage	§ 8.080	The policy shall include information about the Certification of Creditable Coverage in compliance with Section 8.080.		
Prohibition of Discretionary clauses	Chapter 12 / Health Insurance Code § 12.040(A)	No contract, certificate or agreement offered or issued in Puerto Rico by a carrier to provide, deliver, arrange for, pay for or reimburse any of the costs of healthcare services may contain a provision purporting to reserve discretion to carrier to interpret the terms of the contract, or to provide standards of interpretation or review that are inconsistent with the laws of Puerto Rico. An adverse determination by a carrier, as well as disputes or controversies that may arise between a carrier and an enrollee, shall be subject to the internal and external review procedures established in the Health Code.	☐ Yes ☐ No	

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First Level Reviews of Grievances Involving an Adverse Determination	Chapter 22 / Health Insurance Code § 22.070	All carriers must include in the contracts a First Level Revision of Complaints related to an Adverse Determination in compliance with Section 22.070. **The title and language of this section must be included in the contract in the same format and order established in the Section 22.070.**	☐ Yes ☐ No	
Standard Reviews of Grievances Not Involving an Adverse Determination	Chapter 22 / Health Insurance Code § 22.080	All carriers must include in the contracts an Ordinary Revision of Complaints not related to an Adverse Determination in compliance with Section 22.080. **The title and language of this section must be included in the contract in the same format and order established in the Section 22.080.**		
Voluntary Level of Reviews of Grievances	Chapter 22 / Health Insurance Code § 22.090	All carriers must include in the contract a Voluntary Level of Revision of Grievances in compliance with Section 22.090. *(Only applicable to manage care plans)* **The title and language of this section must be included in the contract in the same format and order established in the Section 22.090.**		
Expedited Reviews of Grievances Involving an Adverse Determination	Chapter 22 / Health Insurance Code § 22.100	All carriers must include in the contract an Expedite Review of Grievances involving an Adverse Determination in compliance with Section 22.100. **The title and language of this section must be included in the contract in the same format and order established in the Section 22.100.**		
Urgent care	Chapter 24 / Health Insurance Code § 24.030 (Q)(2)	The contract include the following language, or a different wording with the same meaning, in compliance with this Section: "Any request that a physician with knowledge of the enrollee's medical condition determines is an urgent care request, shall be treated by the carrier as an urgent care request."		
Procedures for Standard Utilization Review and Benefit Determinations	Chapter 24 / Health Insurance Code § 24.090	The policy or contract form includes a description of the utilization review policies and procedures, **The title and language of the provision must be included in the form in the same format and order established in Section 24.090.**		
Procedures for Expedited Utilization Review and Benefit Determinations	Chapter 24 / Health Insurance Code § 24.100	All carriers who perform utilization review procedures must include in its contracts the Procedures for Expedited Utilization Review and Benefit Determinations in compliance with Section 24.100. **The title and language of the provision must be included in the form in the same format and order established in Section 24.100.**		

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Utilization review or benefit determinations for emergency services	Chapter 24 / Health Insurance Code § 24.110	All carriers who perform utilization review procedures must include in its contracts the Procedures for an Utilization Review and Determination of Benefits in respect to Emergency Services in compliance with Section 24.110. **The title and language of the provision must be included in the form in the same format and order established in Section 24.110.**		
Notice of Right to External Review	Chapter 28 / Health Insurance Code § 28.050	All carriers must include in the contracts a Notification of the Right to Request an External Review in compliance with Section 28.050. **The title and language of the provision must be included in the form in the same format and order established in Section 28.050.**		
Request for External Review	Chapter 28 / Health Insurance Code § 28.060	This policy or contract form includes the instructions on how to request an external external review appeal. **The title and language of the provision must be included in the form in the same format and order established in Section 28.060.**		
Exhaustion of Internal Grievance Process	Chapter 28 / Health Insurance Code § 28.070	All carriers must include in the contracts information about the Exhaustion of Internal Grievance Process in compliance with Section 28.070. **The title and language of the provision must be included in the form in the same format and order established in Section 28.070.**		
Standard External Review	Chapter 28 / Health Insurance Code § 28.080	All carriers must include in the contracts information about the Standard External Review in compliance with Section 28.080. **The title and language of the provision must be included in the form in the same format and order established in Section 28.080.**		
Expedited External Review	Chapter 28 / Health Insurance Code § 28.090	All carriers must include in the contracts information about the Expedite External Review in compliance with Section 28.090. **The title and language of the provision must be included in the form in the same format and order established in Section 28.090.**		
External Review of Experimental or Investigational Treatment Adverse Determinations	Chapter 28 / Health Insurance Code § 28.100	All carriers must include in the contracts information about the External Review of Experimental or Investigational Treatment Adverse Determinations in compliance with Section 28.100. **The title and language of the provision must be included in the form in the same format and order established in Section 28.100.**		
Binding Nature of External Review Decision	Chapter 28 / Health Insurance Code § 28.110	All carriers must include in the contracts language in compliance with Section 28.110.		

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Funding of External Review	Chapter 28 / Health Insurance Code § 28.170	All carriers must include in the contracts information about the Funding of External Review in compliance with Section 28.170. **The title and language of the provision must be included in the form in the same format and order established in Section 28.170.**		
Off-label Use	Chapter 52/ Health Insurance Code § 52.040(A)	A health plan that provides coverage for drugs shall provide for the dispensation of any drug covered, regardless of the disorder, injury, illness, condition, or disease for which they were prescribed, provided, that (1) the drug has been approved by the FDA for at least one indication, and (2) the drug is recognized for treatment of the disorder, injury, illness, condition, or disease in one of the standard reference compendia or in substantially accepted peer-reviewed medical literature.		
Off-label Use	Chapter 52 / Health Insurance Code § 52.040(B)	Coverage of a drug shall also include medically necessary services associated with the administration of the drug.		
Newborn and Newly Adopted Children and Children Placed for Adoption	Chapter 54 / Health Insurance Code § 54.050(A) § 54.050(B)	For parent and child/children and/or family coverage, the policy or contract form provides coverage for: (1) A newborn child of a enrollee from the moment of birth; or (2) A newly adopted child of a enrollee from the earlier of: (a) The date of placement in the home of the enrollee for the purpose of adoption and continues in the same manner as other dependents of the enrollee unless the placement is disrupted prior to legal adoption and the child is removed from placement; (b) The date of entry of an order granting the enrollee custody of the child for purposes of adoption; or (c) The effective date of adoption. The coverage shall include coverage of injury or sickness healthcare services including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities; and is NOT subject to any preexisting condition exclusion. **The language of this section must be included in the contract in the same format and order established in Section 54.050(A) and (B).**		

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Newborn notice	Chapter 54 / Health Insurance Code § 54.060(A)	For a newborn child, the carrier shall provide covered enrollees with reasonable notice of the following: (1) If payment of a specific premium or subscription fee is required to provide coverage for a newborn child, the health plan may require the enrollee to notify the carrier of the birth of the child and furnish payment of the required premium or fees within thirty (30) days after the date of birth. (2) If notice and the payment described above are not provided, the carrier may refuse to continue coverage for the child under the health plan beyond the thirty (30)-day period. However, if within four (4) months after the birth of the child the enrollee makes all past-due payments, coverage shall be restored. (3) If payment of a specific premium or subscription fee is not required to provide coverage for a newborn child, the carrier may request notification of the birth of the child, but shall not deny or refuse to continue coverage if the enrollee does not furnish the notice. **The language of this section must be included in the contract in the same format and order established in Section 54.060(A).**		
Newly adopted child or child placed for adoption notice	Chapter 54 / Health Insurance Code § 54.060(B)	For a newly adopted child or child placed for adoption, the carrier shall provide enrollees with reasonable notice of the following: (1) If payment of a specific premium or subscription fee is required to provide coverage for a newly adopted child or child placed for adoption, the health plan may require the enrollee to notify the carrier of the adoption or placement for adoption and furnish payment of the required premium or fees within thirty (30) days after coverage is required to begin under Section 54.050A(2). (2) If the enrollee fails to provide the notice or make the payment described in the preceding paragraph within the thirty (30)-day period, the carrier shall treat the adopted child or child placed for adoption no less favorably than it treats other dependents, other than newborn children, who seek coverage at a time other than when the dependent was first eligible to apply for coverage. **The language of this section must be included in the contract in the same format and order established in Section 54.050(B).**		
No Surprised Bills	Chapter 48 / Health Insurance Code § 48.050(A)	Every insurer must update its website within twenty (20) days after adding or excluding a provider to its network or making any change in the affiliation of a doctor to a facility, provided that, in the case of a change in enrollment, the insurer has received notice of such change.		

NEW!

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No Surprised Bills	Chapter 48 / Health Insurance Code § 48.050(B1)	Every insurer must, in accordance with state or federal law in force, provide the covered person: 1. A clear and understandable description of the plan's out-of-network health benefits, including the methodology used by the entity to determine the allowed amount for out of network services;.			NEW!
No Surprised Bills	Chapter 48 / Health Insurance Code § 48.050(B2)	2. the allowed amount that the plan will reimburse under that methodology and, in cases where a covered person requests the allowable amounts associated with a specific procedure code, the portion of the allowed amount that the plan will reimburse and the portion of the allowed amount to be paid by the covered person, including an explanation that the covered person will be required to pay the difference between the allowed amount as defined by the insurer's plan and charges billed by an out-of-network provider;			NEW!
No Surprised Bills	Chapter 48 / Health Insurance Code § 48.050(B3)	3. examples of anticipated costs for services out-of-network frequently billed			NEW!
No Surprised Bills	Chapter 48 / Health Insurance Code § 48.050(B4)	4. information, in writing and via the website, that reasonably allows a covered person or potential covered person calculate the anticipated cost for out-of-network services, based on the difference between the amount the insurer reimburse for out-of-network services and the usual and customary cost of out-of-network services;			NEW!
No Surprised Bills	Chapter 48 / Health Insurance Code § 48.050(B5)	5. when requested by a covered person, information about whether a health or medical service provider is a member of the network;			NEW!
No Surprised Bills	Chapter 48 / Health Insurance Code § 48.050(B7)	7. access to a direct telephone line that will operate no less than sixteen (16) hours a day, seven (7) days a week, to so consumers can call to find out about network status and costs.			NEW!
No Surprised Bills	Chapter 48 / Health Insurance Code § 48.050(C)	C. If an insurer authorizes an in-network health or medical service provider to perform a covered service under any health plan, and the provider's or facility's status changes to out-of-network before it is performed authorized service, the insurer will notify the covered person as soon as possible. If the insurer does not provide notice at least thirty (30) days before the authorized service is performed, the financial responsibility of the covered person will be limited to the financial responsibility that would have been incurred if the provider had been in-network. of the person's health plan.			NEW!

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No Surprised Bills	Chapter 48 / Health Insurance Code § 48.050(D)	D. Every insurer will add to your Benefits Information, to all reimbursement correspondence to the covered person, and to the provider, a clear and concise notice that inadvertent and involuntary out-of-network charges are not subject to collection or billing beyond the financial responsibility incurred under the terms of the contract of service within of the network. Any attempt by the provider to charge or bill must be reported immediately to the insurer's customer service department, at the telephone number that the insurer will provide in the Benefits Information and all correspondence regarding reimbursement to the covered person.			NEW!
No Surprised Bills	Chapter 48 / Health Insurance Code § 48.120	A. Every insurer shall provide each covered person with written notice, in the form and manner prescribed by the Commissioner of Insurance, regarding the protections provided to covered persons pursuant to this Chapter. The notice will include information about how a consumer may contact the Office of the Commissioner of Insurance to report or dispute an out-of-network charge. This notice will also be published on the insurer's website.			NEW!
Unfair Discrimination against Victims of Abuse	Chapter 72 / Health Insurance Code § 72.040(A)	The following language in compliance with Section 72.040 must be included in the contract. It is unfairly discriminatory to: (1) Deny, refuse to issue, renew or reissue, cancel or otherwise terminate a health plan, or restrict a health plan coverage or add a premium differential or surcharge to any health plan on the basis of the enrollee's abuse status; or (2) Exclude, limit coverage, or deny a claim on the basis of the enrollee's abuse status. **The language of this section must be included in the contract in the same format and order established in the Section 72.040(A).**			
OTHER REQUIREMENTS FOR HEALTH SERVICES ORGANIZATIONS					
Evidence of Coverage	Chapter 19/ Insurance Code § 1908	Evidence of coverage must be submitted in compliance with this section. If the contract will be use as the evidence of coverage, the carrier disclosed this information in the cover letter.	☐ Yes ☐ No		

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Prohibited words	Chapter 19/ Insurance Code § 1915(4)	No health service organization may use in its name, contract or literature, any of the words "insurance", "contingency", "guaranty", "mutual", or any other word describing insurance, contingency or guaranty business, deceitfully similar to the name or description of any insurance or guaranty corporation doing business in Puerto Rico. **The terms "insurer"," insured", "insurance", "insurance company", "policy", "insure" cannot be use.**	☐ Yes ☐ No		
Puerto Rico Laws					
Psicologist uniform definition	Act No. 79 December 30, 2021	Establish the definition of the term “Psychologist” or “Psychologist” established by Law 194, supra, and Law 296, supra, are uniform with the definition of said term established by Law 408-2000, as amended, known as the “Law of Puerto Rico Mental Health. Also amends Law 220-2012 and Law 239-2012			NEW!
Psicologist uniform definition	Act No. 79 December 30, 2021 Section 1	Subsections (n) and (q) of Section 2 of Act 194-2000, as amended, are amended to read as follows: **(n) "Health Professional"** – shall mean any practitioner duly admitted to practice in Puerto Rico, in accordance with applicable laws and regulations, any of the health and medical care professions, such as, but not limited to, physicians, surgeons, podiatrists, naturopathic doctors, chiropractors, optometrists, psychologists, dentists, pharmacists , nurses, audiologists and medical technologists, as authorized by the corresponding laws of Puerto Rico.			NEW!
Psicologist uniform definition	Act No. 79 December 30, 2021 Section 1	**q) “Psychologist”** - means the professional licensed by the Board Examiner of Psychologists of the Commonwealth of Puerto Rico, as defined in Act No. 96 of June 4, 1983, as amended, known as the "Act to Regulate the Practice of the Profession of Psychology in Puerto Rico", which has training, knowledge, skills, and experience in providing services including, but not limited to: prevention, description or diagnosis of behavior, psychological evaluation, therapeutic intervention with psychological problems of various levels of severity and consulting concerning the intellectual, emotional, behavioral, interpersonal, family, social and occupational functioning of individuals and groups. The license conferred by the Board explicitly requires all professional psychologist to practice according to their training and competencies under the legal provisions and the ethical norms that regulate this practice in Puerto Rico.			NEW!

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Medical Emergency Technicians-paramedics	Act No. 69 December 27, 2021	Item 5 of Article 19.030 of the Insurance Code is amended to read as follows: (5) Every health service organization that provides health services must include, as part of its coverage, if there is medical justification according to the criteria established in the protocols created by the Department of Health and according to the home care plan. , to people who require a ventilator to stay alive, a minimum of one daily shift of eight (8) hours of nurses or nurses; or paramedical emergency medical technicians (TEM-P), duly licensed. In addition, duly licensed emergency medical technicians-paramedics (TEM-P) must have approved and validated courses, certifications and training or the skills and knowledge requirements established by regulation by their respective Examining Board related to the care and management of said patients. and its medical equipment as authorized in this Law."			NEW!
Protection against surprised medical bills - New Chapter 48 Health Insurance Code of Puerto Rico	Act No. 134 September 1, 2020	The purposes of stopping the so-called "surprise bills" in the billing of health plans, establish consumer protections, transparency, cost control and responsibility, out of network providers; and for other related purposes.			NEW!
Braille system (Blind) evidence of cover and ID card	Act No. 162 December 30, 2020	Article 19.080 of the Insurance Code is amended to read as follows: (1) (a) Each subscriber is entitled to evidence of coverage. If the subscriber obtains coverage through an insurance policy, the insurer will issue the evidence of coverage. Otherwise, the health service organization will issue the evidence of coverage. In the case of blind subscribers the evidence of coverage and the identification card will be issued in the Braille system			
Clinical Review Criteria	Act No. 142 October 9, 2020 Amends Section 2.030 (E) of the Health Insurance Code	E. "**Clinical Review Criteria**" means the written screening procedures, decision summaries, clinical protocols, and practice guidelines used by the health insurance organization or insurer to determine the medical necessity and appropriateness of the medical service. health care. These practice guides are not mandatory for the Health Professional in the exercise of their functions when providing any health care service in accordance with state and federal laws and corresponding regulations; and as long as the service provided is recognized by the generally accepted standards of health and medical practice, in the light of modern means of communication and teaching. The professional diagnosis will be the guiding and exclusive criterion to determine the treatment to be followed in a patient. Therefore, professional judgment cannot be altered by the insurer. Notwithstanding the foregoing, the provisions of this subsection must comply with federal laws and regulations on the matter.			

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Requirements and Procedures for Approval of Medical Exceptions.	Act No. 142 October 9, 2020 Amends Section 4.070 (B) 1st paragraph of the Health Insurance Code	B. The health insurance organization or insurer that provides prescription drug benefits, the PBM or any other entity to which the administration of pharmacy services has been delegated, will have the obligation to offer immediate temporary coverage for an initial prescription. of the prescription drug during the medical exception request process and until you notify your final determination in writing, when the physician or health care professional who issued the prescription establishes in writing that the requested prescription drug is medically necessary for the treatment of the illness or condition of the covered or insured person; even when said prescription drug is one of which is excluded from the drug formulary of the covered or insured person's medical plan or is subject to a prescription drug management procedure established in this Article. The health insurance organization or insurer that provides prescription drug benefits, the PBM or any other entity to which the administration of pharmacy services has been delegated, must pay the pharmacy the initial prescription of the dispensed medication, in what the insurer awards the prescription drug coverage. The pharmacy may submit an electronic invoice to the insurer for the payment of the initial prescription for dispensed drugs and the insurer will be required to accept electronic invoicing and may not require a physical or paper invoice as a condition for payment. Thus, under no circumstances will the covered or insured person be deprived of their prescription drug while they are in the process of requesting medical exceptions as established in this Article, or the presentation of a complaint in accordance with the Chapter on Internal Complaint Procedures of Health Insurance Organizations or Insurers of this Code. This rule for temporary coverage of initial prescription drug prescriptions will not affect existing regulations on transitional drugs. Notwithstanding the foregoing, the provisions of this subsection must comply with federal laws and regulations on the matter.		
Requirements and Procedures for Approval of Medical Exceptions.	Act No. 142 October 9, 2020 Amends Section 4.070 (B) 2nd paragraph of the Health Insurance Code	Any health insurance organization or insurer that provides prescription drug benefits, pharmacy benefits manager or administrator or any entity to which the administration or management of pharmacy services or benefits has been delegated, will include in the calculation or in the requirement of contribution or cost sharing (“cost sharing, out-of-pocket maximun”), any payment, discount or item that is part of a financial assistance program, discount plan, coupons, or any contribution offered to the insured by the manufacturer. These items will be considered for the exclusive benefit of the patient in the calculation of their contribution, out-of-pocket expenses, co-payments, co-insurance, deductible or in compliance with shared contribution requirements. These contributions, discounts and coupons from the manufacturer will be available and may be used in all health providers, according to the requirements of the program, regardless of the place of acquisition of the discount or coupon. The use of the accumulator of benefits, maximizer or any other similar program that has the effect of implementing a restriction on liability established in this subsection is prohibited.		

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Requirements and Procedures for Approval of Medical Exceptions.	Act No. 142 October 9, 2020 Amends Section 4.070 (E) (1) of the Health Insurance Code	1) The procedure for requesting medical exceptions provided in this Article shall require that the health insurance organization or insurer that provides prescription drug benefits, the PBM or any other entity to which the administration of the pharmacy services, make the determination regarding a request submitted and notify said determination to the covered person or insured, or his personal representative, with the urgency required by the medical condition of the covered person or insured, but in no case may the notification Exceed forty-eight (48) hours from the date of receipt of the request, or the date of receipt of the certification, in the event that the health insurance organization or insurer requests it in accordance with section B (2) , whichever is later of the dates. In the case of controlled medications, this term should not exceed twenty-four (24) hours.		
Special Law to Ensure Access to Treatment and Diagnosis of Cancer Patients in Puerto Rico.	Act No. 79 August 1, 2020 Section 5	Every insurer or health insurance organization that provides individual or group medical plans must have coverage available that includes mandatory treatments, medications and diagnostic tests, included in the guidelines of the National Comprehensive Cancer Network ("NCCN Guideliness") and / or approved by the Food and Drug Administration (FDA, for its acronym in English), as well as those necessary to attend and minimize its adverse effects, subject to the provisions of this Law. The “Local Coverage Determinations-LCD from First Coast Service Options, INC ”,“ Medicare Approved Compendia List ”,“ National Coverage Determations Alphabetical Index ”,“ Milliman Care Guidelines ”and ASES Internal Guidelines. Nothing provided in this Article shall be understood as prohibiting an insurer or health insurance organization from providing services, or including coverage of drugs or tests that are broader than those described herein.		
Special Law to Ensure Access to Treatment and Diagnosis of Cancer Patients in Puerto Rico.	Act No. 79 August 1, 2020 Section 6	Any individual or group medical plan that includes the prescription or coverage of medications, treatments and diagnostic tests must submit approval or denial of medications, treatments and diagnostic tests listed in the guidelines of the National Comprehensive Cancer Network (“NCCN Guideliness ”) Or those approved by the Food and Drug Administration (FDA), within a term of 24 to 72 hours of receipt of the request or within a term of 24 hours, if it is a case marked urgent or expedited. Provided that, of the individual or group medical plan, not issuing its determination within said term, it will be understood that the medications, treatments and / or diagnostic tests were approved by the same.		
Special Law to Ensure Access to Treatment and Diagnosis of Cancer Patients in Puerto Rico.	Act No. 79 August 1, 2020 Section 7	Any medical plan, individual or group, that requires the appointment of a primary care provider, may allow the appointment, in cancer patients, of a doctor specialized in oncology, as primary care provider; as long as that health professional consents to such designation.		

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Special Law to Ensure Access to Treatment and Diagnosis of Cancer Patients in Puerto Rico.	Act No. 79 August 1, 2020 Section 8	The rights established in this Act will be additional to those provided by Act 275-2012, as amended, known as the "Bill of Rights of Cancer Patients and Survivors", and will have the scope and will be governed in accordance with the requirements and procedures provided by Public Law 111-148, known as the “Patient Protection and Affordable Care Act”, Public Law 111-152, known as the “Health Care and Education Reconciliation Act” and the federal and local regulations adopted under this and any other law or regulation that is successor or applicable at the federal or local level. Every patient will have the right to receive the treatment that his doctor recommends, without limitations by the insurers, that the patient receives a more effective and cutting-edge treatment, available in the market, in accordance with the coverage and protocols designed to the protection of Articles 5 and 9 of this Law. The policies, contracts, certificates or agreements offered or issued in Puerto Rico by a health insurance organization or insurer to provide, deliver, process, pay or reimburse the cost of health care services, treatments, medications or diagnostic tests included as mandatory and uniform, they will not provide that the final interpretation of the terms of the contract will be subject to the discretion of the health insurance organization or insurer, nor will they contain interpretation or review rules that contravene the provisions of this Law.		
To amend Law No. 168 of 2018, Law for the use of Telemedicine in Puerto Rico.	Act No. 68 July 16, 2020 Amends Act No. 168 August 1, 2018 Section 13 (1), (2)	The provisions included below regarding the practice of telemedicine and telehealth will apply as a result of the emergency declaration promulgated by the Governor of Puerto Rico through Administrative Bulletin No. OE-2020-020 as a consequence of the SARS-CoV-2 coronavirus, known as COVID-19. (1) Physicians and health professionals covered by this Act may use their own telemedicine or telehealth technology to care for their patients, without the need to have the corresponding Certification from the Licensing Board or their respective Examining Board. u Governing Body. (2) The Examining Board or Governing Body of each health profession covered by this Law, must immediately establish the basic guidelines to be able to attend patients using telehealth technology and notify the corresponding group of health professionals so that they can begin to use such mechanisms. No health professional authorized to practice in Puerto Rico may begin to care for patients using telehealth's own technology, until their respective board or governing body issues the corresponding guidelines according to the nature of the declared emergency. This subsection will not apply to doctors authorized to practice telemedicine as established in Joint Resolution 19-2020.		

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To amend Law No. 168 of 2018, Law for the use of Telemedicine in Puerto Rico.	Act No. 68 July 16, 2020 Amends Act No. 168 August 1, 2018 Section 13 (3), (4)	(3) All the services offered in accordance with the provisions of this Article will be subject to and will respond to the same standards of care, competence and professional conduct applicable to the offering of said services in person. Recording of therapeutic consultations, sessions or conversations is prohibited. (4) The authorization outlined in this Article does not exempt doctors and health professionals, with the fulfillment of the requirements of their respective licenses and / or ethical standards, for which they will be subject to the corresponding sanctions.		
To amend Law No. 168 of 2018, Law for the use of Telemedicine in Puerto Rico.	Act No. 68 July 16, 2020 Amends Act No. 168 August 1, 2018 Section 13 (5), (6), (7)	(5) Regardless of what is established in this Article, patient privacy will always be respected in accordance with the provisions of the Health Insurance Portability Accountability Act of 1996 or any other applicable state or federal statute or regulation. Both the Licensing Board and the Examining Board or Governing Body may adopt all the measures they deem necessary to ensure that the health providers they regulate protect the privacy of their patients; These measures must be in accordance with any applicable federal law or regulation. (6) Health insurance companies, insurers, health service organizations, pharmacy benefit managers or managers, the Health Insurance Administration (ASES) and related entities contracted by them, will be required to include within the coverage basic and pay from state or federal funds those diagnostic tests and / or medical treatment present or future to treat COVID-19, according to the prices established by the Center for Medicare & Medicaid Services (CMS) of the Department of Health and Human Services from the United States. Likewise, the ASES will temper its requirements to eliminate the signature of the primary physician on a prescription, referral and medical order. (7) As a measure to reduce personal contact, contagion and discourage citizens from going to doctors' offices, pharmacies are ordered to dispatch refills of those chronic medications even if the patient does not have available refills or a new prescription . For this, the patient must show the empty medicine bottle in which the dose and the identity of the patient are specified. Medicines classified as controlled in classifications II, III, IV or V by federal or state laws or regulations, as well as narcotics regardless of their classification, are excepted from the foregoing.		

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To amend Law No. 168 of 2018, Law for the use of Telemedicine in Puerto Rico.	Act No. 68 July 16, 2020 Amends Act No. 168 August 1, 2018 Section 13 (8), (9), (10), (11)	(8) Any permanent or temporary building that is enabled in a service facility to attend in isolation to patients with symptoms of this virus, will be considered for all relevant legal purposes as an extension of health services in which it is located. (9) As long as this COVID-19 emergency persists, any doctor or health professional who is authorized by law to prepare prescriptions, referrals, medical order or order treatments, tests or examinations to the patient, may send the prescription, referral or order by photography or any other electronic method and the service provider that receives it will be obliged to accept it. The prescription must be sent directly by the doctor or health professional, for which reason prescriptions sent by photographs to the patient directly will not be accepted. (10) The doctors and health professionals authorized here will keep all the information necessary to document the services provided. In order to avoid insurance fraud, insurance companies, health service organizations and ASES may carry out the pertinent verifications to corroborate that, in effect, the services have been provided by the telemedicine or telehealth means themselves. (11) The doctors and health professionals authorized here must comply with the informed consent provisions established in this Law.		
To amend Law No. 168 of 2018, Law for the use of Telemedicine in Puerto Rico.	Act No. 68 July 16, 2020 Amends Act No. 168 August 1, 2018 Section 13 (12)	(12) Billing: (a) Any doctor or health professional authorized to practice in Puerto Rico may bill the services provided using telemedicine or telehealth technology and health insurance companies, insurers, health service organizations, administrators or managers of pharmacy benefits , the ASES and related entities hired by them, will be obliged to pay it as if it were a face-to-face consultation. For these purposes, they will have to provide physicians and health professionals who so request with the corresponding codes for billing for health services provided using the technology of telemedicine or telehealth. No health insurance company, insurers, health service organizations, pharmacy benefit administrators or managers, the ASES or related entities, may refuse to pay for a service provided that is not properly codified, if its rules and procedures allow it. create the codes and / or procedures to conform to the provisions of this Law. In the case of doctors or health professionals who provide their services in accordance with this Law, but whose services are not duly codified by the ASES or a health insurance company and there is a statutory, normative, procedural or regulatory impediment to codify it, they may bill for the services provided as they normally do for a face-to-face consultation, but they must deduct ten percent (10%) from the billing of the total cost. (b) When the doctor or health professional authorized by this Article, provides their services through medical plans or health insurance, and the patient receives the services, he or she will be exempt from paying the fixed amount paid for these services or the copayment that would ordinarily pay in a face-to-face consultation, during the term of the emergency declared by the Governor as a result of COVID-19.		

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Law to Regulate Cyber Therapy in Puerto Rico	Act No. 48 April 29, 2020	"Cyber therapy" is the distance practice of the professions described in the preceding paragraph, in which the individual-therapist interaction is mediated by technological communication and information tools. They should include, but are not limited to, diagnostic services, evaluation, analysis, consultation, supervision, information, education, interpretation and intervention with the needs and expectations of the individual who receives them. The practice of cyber therapy must take into consideration those aspects as defined by the "Center for Medicare Services" (CMS, for its acronym in English), so that the consultations made may be considered for reimbursement by "Medicare" or " Medicaid "		
Law to combat Covid-19	Act No. 43 April 16, 2020	All medical care, study, analysis, diagnosis and treatment of COVID-19, including hospitalization, will be free of charge for all citizens, regardless of whether they have health insurance or not. *No health insurance organization, insurer, PBM or third-party administrators may require any copayment, deductible, pre-authorization or referral to the patient, for medical care, studies, analysis, diagnosis and treatment of COVID-19, including hospitalization, as long as these services are provided in Puerto Rico.		

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Diabetes Equipment and Supplies Coverage	Act No. 19 January 12, 2020 Amends Act No. 177 of August 13, 2016 Ruling Letter No. CN-2016-209-AS	Health Plans should include, as part of their basic coverage the supply of a glucose monitor every three (3) years with replacement of damaged equipment, the supply of one (1) glucagon injection and replacement of it in case of use or expiration, and a minimum of one hundred and fifty (150) strips and one hundred and fifty (150) lancets each month for patients diagnosed with type I diabetes mellitus by a specialist in pediatric endocrinology or endocrinology. The coverage should also include the portable insulin infusion pump or microinfuser, as therapy for patients diagnosed with Type I Diabetes Mellitus. Section 4 of Law 177-2016, as amended, is amended to read as follows: “Once the patient has been diagnosed with the condition of type I diabetes mellitus, for the patient to receive the benefit established under this Law, they must submit a prescription properly Issued by a medical practitioner duly authorized to practice the profession within the jurisdiction of Puerto Rico so that a pharmacist will dispense in his original box duly sealed the authorized monthly strips and lancets under this Act.” **Ruling Letter No. CN-2016-209-AS:** Coverage must clearly indicate that the carrier will cover the glucometer brand ordered by the endocrinologist whenever there is a justification submitted. With regard to coverage for the insulin infusion pump, the selection of the brand of this device will be determined by the endocrinologist based on the age of the enrollee, the level of physical activity of the enrollee, and the enrollee's and/or the caregiver’s knowledge regarding the condition.		

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Law on the Right to Effective Detection of Breast Cancer	Act No. 10 January 3, 2020	Every insurer or health services organization will provide, as part of the benefits of preventive care of its basic coverage, mammograms and other breast cancer diagnosis and detection tests, according to acceptable practices, in accordance with the following: a.a baseline mammogram, for women between thirty-five (35) and thirty-nine (39) years, b.an annual mammogram for women forty (40) years of age or older c.an annual mammogram, follow-up treatment or supplementary diagnostic tests: i. to women of forty (40) years of age or older, who have breasts of tissue classified as heterogeneously dense or extremely dense, as determined by mammography by a radiologist, based on the breast density scale of the Image and System Projection Report Breast Imaging Reporting and Data System, BI-RADS, promulgated by the American College of Radiology ii.to women at high risk of developing breast cancer because: 1.to your family history 2.to his own history as a cancer patient 3.presence of high-risk markers in your genetic profile or 4.Some other factor determined by your doctor. Follow-up treatment or supplementary diagnostic tests for the detection of breast cancer in women aged forty (40) or older, who have breasts of tissue classified as heterogeneously dense or extremely dense, may include, but is not limited to the list of content criteria established in this law.		
Ambulance ground transportation coverage for medical emergencies	Act No. 129 August 1, 2019	Every insurer, health service organization or other health plan provider authorized to operate in Puerto Rico must include in its basic plan or insurance, the ambulance ground transportation cover for medical emergencies. Transportation service through the 9-1-1 Emergency System, due to a medical emergency, must be paid to the ambulance provider directly for the cost of transportation. Any entity responsible for the health of a patient shall be obliged to honor, at a minimum, the rates established by Regulation of the Bureau of Transportation and other Public Services (Negociado de Transporte y otros Servicios Publicos), attached to the Puerto Rico Public Service Regulatory Board (Junta Reglamentadora de Servicio Público de Puerto Rico). **Act No. 383-2000**, known as the "Law to Prohibit Health Plans, Nonprofit Organizations Offering Health Services," is repealed, for being in conflict with the provisions contained in this Law.		

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Treatment of hyperbaric oxygenation to people diagnosed with Autism	Act No. 63 July 19, 2019	Health plans must include, as part of their coverage, the treatment of hyperbaric oxygenation to people diagnosed with Autism Spectrum Disorder, provided that it is recommended by a certified medical or healthcare professional and the treatment is allowed by law and federal regulations.		
Telemedicine	Act No. 168 August 1, 2018	The policy or contract form may, if applicable, provide coverage for a telemedicine program. In such case, the policy or contract form should include: 1. The definition of telemedicine in compliance with Act No. 168 -2018, and 2. A description of the telemedicine program, including how the covered persons can access the program. 3. If the coverage is subject to deductibles, copayments, and/or coinsurance, the same shall be disclosed.		
Down syndrome	Act No. 97 May 15, 2018	The policy or contract form shall cover tests, not limited to, genetics, neurology, immunology, gastroenterology and nutrition. Also, shall cover visits and tests referred by a physician, and therapeutic services with a remediative approach to independent living or assisted living for adults over 21 years of age. The carrier will not rescind, refuse, deny coverage or services if an insured is diagnosed with Down Syndrome. The carrier will not cancel an existing health policy if one of the beneficiaries is diagnosed with Down Syndrome and it was unknown at the time of obtaining the policy.		
Phenylketonuria (PKU)	Act No. 139 August 8, 2016	Health plans must include as part of the basic coverage, the "Phenylalanine Free Amino Acids **Preparation**" for enrollees diagnosed with the genetic disorder called phenylketonuria (PKU), with no enrollee age exclusions. **This mandatory coverage is in addition to the recommended preventive service of screening for the genetic disorder (PKU) in newborns.**		
Human Immunodeficiency Virus (HIV)	Act No. 45 May 16, 2016	Health plans must include, as part of the basic coverage, an HIV test a year as part of the routine studies for any medical evaluation, except for pregnant women to which apply the following requirements as established by the USPSTF: 1) A first HIV test during the first trimester of pregnancy at the first prenatal visit, and 2) A second test during the third trimester of pregnancy (between the (28) and (34) weeks of pregnancy.		

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Technological equipment	Act No. 62 May 4, 2015 Amends Act No. 125 of September 21, 2007	Health plans must include, as part of the coverage, the technological equipment whose use may be necessary to maintain the user alive, a minimum of one (1) daily eight (8) hour shift of nursing services provided by skilled nurses knowledgeable in respiratory therapy or specialists in respiratory therapy with nursing skills, the supplies needed to operate technological equipment and the physical and occupational therapy needed to develop the motor skills of these enrollees. For the purposes of this law, a user shall be understood to be those who use medical technology as well as children with tracheotomy to breath, and whose operation depends on medical equipment, ventilator or supplemental oxygen and those who have started treatment as minors and meet twenty (21) years and who received medical services or receive home care, continue to receive these services after serving twenty (21) years of age.		
Cancer	Act No. 275 September 27, 2012 Section 3(A)(g)	No carrier shall reject or deny any treatment agreed upon and/or included as part of the terms and conditions of the contract signed by the parties when a medical recommendation to such purposes so require. Physicians, carriers and providers shall not reject or deny treatment such as hospitalization, diagnosis, and medication to any cancer patient enrollee. With regard to cancer survivors, carriers and healthcare plans providers shall not deny coverage for the treatment and frequent and permanent monitoring of the physical health and emotional wellbeing of the enrollee.		
Cervical cancer	Act No. 275 September 27, 2012 Section 3(E)(c)	Coverage shall include pelvic exams and all types of vaginal cytology that may be required by a physician to detect, diagnose, and treat early stages of abnormalities that may lead to Cervical Cancer.		
Breast cancer	Act No. 275 September 27, 2012 Section 3(E)(d)	Every health plan shall provide extended coverage for the payment of breast cancer screening and testing such as visits to specialists, clinical breast exams, mammograms, digital mammograms, magnetic resonance mammography and breast ultrasounds, and treatment including, but not limited to, mastectomy (including males), breast reconstruction after mastectomy, reconstructive surgery of the other breast to achieve symmetry, breast prosthesis, treatment for physical complications at all stages of mastectomy, including lymphedema (swelling that sometimes occurs after breast cancer treatment), any reconstructive surgery after mastectomy that may be needed for the physical and emotional recovery of the enrollee.		

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Human papilloma virus (HPV) vaccine	Act No. 255 September 15, 2012	Health plan shall cover the vaccine against the human papilloma virus (HPV) for males and females; according to the recommendations of the Advisory Committee on Immunization Practices (ACIP) and the Centers for Disease Control and Prevention (CDC). HPV vaccination beginning at age 9 years for children and youth with any history of sexual abuse or assault who have not initiated or complete the 3 doses series (ACIP recommendation). No cost sharing is applicable.		
Psychology professionals services	Act No. 239 September 13, 2012	Health plans shall include services provided by psychology professionals trained by education with a master degree or PhD, trainings and experience to provide health care services, duly licensed by the Puerto Rico Board of Psychologist Examiners.		
Autism Spectrum Disorder	Act No. 220 September 4, 2012 Section 15	Every health plan shall provide coverage for the treatment of autism. This coverage should include, but not limited to, genetics, neurology, immunology, gastroenterology and nutrition; speech, language, psychological, occupational, and physical therapies; and will include physician office visit and the medical tests referred by them.		
Screening tests	Act No. 218 August 30, 2012 Sections 2 and 3	As part of their coverage carriers shall include, without this constituting a limitation, access to tests of: cancer, high blood pressure and cholesterol, diabetes, osteoporosis, and sexually transmitted diseases.		
Chemotherapy	Act No. 107 June 5, 2012 Section 1	A health plan that provides coverage for treatment of chemotherapy against cancer must also provide coverage of the chemotherapy against cancer in their various methods of administration of the drug, such as intravenous, oral, injectable track or intrathecal route; according to the order of the specialist doctor or oncologist.		
Designation of Primary Care Provider and Direct Access to OB/GYN Services	Act No. 161 November 1, 2010 Section 6(i)	A health plan must cover direct access to gynecology and obstetrics care services without requiring referrals or previous authorization, insofar as such physician participates in the network of the healthcare providers.		
Designation of Primary Care Provider and access to pediatricians	Act No. 161 November 1, 2010 Section 6(j)	A health plan providing coverage for a minor as an enrollee must allow the parent or tutor to select a pediatrician as his/her primary care provider, insofar as such pediatrician participates in the network of healthcare providers.		
Prescription Opioid Drugs	Act No. 140 September 22, 2010	A health plan shall include, as part of the coverage, the medication known as buprenorphine for treatment of opioid dependence in the “Medicaid Preferred Drug List,” or the preferred drug list.		

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Bariatric surgery	Act No. 212 August 9, 2008	All carriers shall provide, subject to preauthorization, coverage for one (1) bariatric surgery per lifetime for the treatment of morbid obesity using one of the following techniques: gastric bypass, adjustable gastric band or sleeve gastrectomy. The intragastric balloon technique is excluded from the law. The carrier may require a waiting period that shall not exceed twelve (12) months, before cover for the benefits stipulated in this act. For the preauthorization of these services, the first treatment for the morbid obesity should be dietetic and in changes in the life style. The physician must document the unsuccessful attempt(s) with nonoperative medically supervised weight reduction program(s). For purposes of this act, morbid obesity means a body mass index of at least thirty-five (35) kilograms per meter squared, or greater. Bariatric surgery refers to the various surgical procedures performed to treat obesity, which can be practice by the following four techniques: gastric bypass, adjustable gastric band or sleeve gastrectomy or intragastric balloon.		
Dependents	Act No. 116 July 17, 2008	Amends Act No. 15 of February 27, 2007, in order to correct the scope of the measure and to extend the term of effectiveness of said act. Provides that the underwriters of the carriers in Puerto Rico shall accept, in a family coverage, the inclusion as enrollees of minors whose custody or guardianship has been granted to the grandparents or other participating family members, and those of legal age who have been declared disabled, whose guardianship has been granted, when the person to whom custody or guardianship has been granted is the primary enrollee of the health plan.		
Naturopathic Physician	Act No. 210 December 14, 2007	A health plan shall provide access to the health services and treatment by a ***naturopathic physician***, if the coverage provided by the health plan offers any service included in the "spectrum of practice" of a licensed naturopathic physician, authorized by the Commonwealth of Puerto Rico. Also, the contract must disclose the applicable copayment or coinsurance.		
Audiology	Act No. 127 September 27, 2007	A health plan shall provide access to the health services and treatment by an audiologist, if the coverage provided by the health plan offers any service included in the "spectrum of practice" of a licensed audiologist physician, authorized by the Commonwealth of Puerto Rico. Also, the contract must disclose the applicable copayment or coinsurance.		
Respiratory syncytial virus (RSV)	Act No. 165 August 30, 2006	All carriers are required to include in the contract the vaccine against respiratory syncytial virus as part of their pediatrics coverage.		

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Chiropractor	Act No. 150 August 8, 2006	A health plan shall provide access to the health services and treatment by a chiropractor, if the coverage provided by the health plan offers any service included in the "spectrum of practice" of a licensed chiropractor, authorized by the Commonwealth of Puerto Rico. Also, the contract must disclose the applicable copayment or coinsurance.		
Universal Neonatal Hearing Screening Test	Act No. 311 December 19, 2003	A contract which is available or may be available, renewed, extended, or modified in Puerto Rico by any carrier with benefits applicable within the contract, shall include coverage for initial hearing screening and for any other hearing evaluation within the follow-up care related to the hearing screening described in this act. As provided by the act, the service shall be rendered in Puerto Rico even though the carrier is located outside of Puerto Rico. The benefits of the Universal Neonatal Hearing Screening Test to newborn babies, as well as the follow-up care shall be subject to the same co-payment and co-insurance provisions applicable to any other medical service. With the exception that the benefit of neonatal hearing screening shall be exempted from co-payments/coinsurance or provisions that limit the maximum amount to be paid by the carrier.		
Health Professionals definition	Act No. 148 August 9, 2002 Section 6(d)	A health plan shall provide access to the health services and treatment by a podiatrist, optometrist or psychologist, if the coverage provided by the health plan offers any service included in the "spectrum of practice" of a licensed podiatrist, optometrist and clinical psychologist, authorized by the Commonwealth of Puerto Rico. Also, the contract must disclose the applicable copayment or coinsurance.	**AMENDED BY LAW 79-2021**	
Health Professionals definition	Act No. 194 August 25, 2000 Section 6	Defines “Health Professional” as any practitioner duly allowed to practice in Puerto Rico, according to the applicable act and regulations, any of the health and medical care health professions including but not limited to, physicians, surgeons, dentists, pharmacists, nurses and medical technologists, as authorized by the corresponding act of Puerto Rico.	**AMENDED BY LAW 79-2021**	
Termination	Act No. 194 August 25, 2000 Section 7(a)	A contract shall contain a clause providing that in cases in which health plan coverage is terminated or cancelled, or coverage by a provider is terminated or cancelled, the carrier shall notify the enrollee of such termination or cancellation thirty (30) calendar days before the date such termination or cancellation becomes effective.		

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Extension of Benefits	Act No. 194 August 25, 2000 Section 7(b)	The contract shall contain a clause providing that subject to payment of premium as required, should the health plan or the provider terminate coverage, the enrollee may continue receiving the benefits thereof for a transitional period of ninety (90) days as of the date the health plan or the provider terminates coverage. 1. In those cases in which the enrollee is hospitalized at the time of the date of said termination of coverage, and the release of the enrollee from the hospital has been scheduled for a date preceding the date of termination of coverage, the transition period shall be extended from said date to ninety (90) days after the date the enrollee is released. 2. In those cases in which the enrollee is in her second trimester of pregnancy as of the date of termination of coverage and the provider has been offering medical treatment pertinent to the pregnancy before the date of termination of coverage, the transitional period concerning pregnancy-related health care shall be extended to the date the mother is released from hospital after childbirth, or the date the newborn is released from the hospital, or both, whichever occurs later. 3. In those cases in which the enrollee is diagnosed a terminal condition before the date of termination of coverage and the provider has been offering medical treatment pertinent to the condition before said date, the transitional period shall be extended for the remainder of the enrollee's life. Providers that continue the treatment of the enrollees during said period must accept the payments and rates fixed by the health plan as full payment for services rendered, as well as continue providing the plan with all the necessary information required for purposes of quality control, and surrender or transfer the medical records corresponding to the enrollees upon termination of said transitional period.		
Emergency services	Act No. 194 August 25, 2000 Section 8(c)	A health plan shall provide emergency service benefits with no waiting period. The previous authorization of the carrier shall not be required when providing these emergency services. Furthermore, these services shall be provided regardless of whether the provider of such emergency services is a participating provider. In the event that an enrollee is provided services by a provider not contracted by the carrier, the enrollee shall not be held liable for the payment of services in an amount exceeding the amount applicable if the enrollee had received such services from a provider contracted by the carrier. The carrier shall compensate the provider offering the services, and the provider shall be under the obligation to accept said compensation, for an amount not to be less than the agreed with the providers contracted by the carrier to offer the very same services. Moreover, under these circumstances, such emergency services shall be provided regardless of the conditions set forth by the corresponding health plan.		

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Experimental or Investigational Treatment	Act No. 194 August 25, 2000 Section 9(g)	A health plan shall contain a provision setting forth that the carrier shall pay the routine medical expenses of any enrollee suffering from a life-threatening condition for which there is no effective treatment, when the enrollee is eligible for participating in an authorized clinical treatment study pursuant to the study protocol provisions concerning said treatment, provided the participation of the enrollee offers a potential benefit to he/she and the physician referring the enrollee believes that participation in said study is pertinent, or the enrollee presents evidence of the fact that participation in said study is pertinent. Routine medical expenses of the enrollee shall not be construed to be expenses related to the study, or tests administered to be used as part of the study, or expenses the entity conducting the study is likely to pay.		
HIV/AIDS Virus	Act No. 349 September 1, 2000	Bill of Rights for carriers of the HIV/AIDS Virus in Puerto Rico. Right to the best assistance and treatment, **without any restriction**, to guarantee a better quality of life.		
Maternity Care	Act No. 248 August 15, 1999	Any carrier that provides maternity benefits shall provide a minimum coverage of forty eight (48) hours of care in the hospital facilities in benefit of the mother and her newborn child (or children) if it is a natural birth without complications, and a minimum of ninety-six (96) hours if she required a caesarean section. Any decision that has the effect of shortening the period of time provided above shall have to be determined by the attending purveyor with the acceptance of the enrollee. If the mother and the newborn are released within a period that is less than what is provided in this section, but in accordance with the second paragraph, the coverage shall provide for a follow-up visit within the next forty-eight (48) hours. The services shall include, but shall not be limited to the attention and physical care of the child, instruction on the care of the child for both parents, help and training on breast feeding, information regarding home care, and the provision of any treatment, and medical tests for the infant as well as for the mother. The language of the contract include the act number and its date of approval.	☐ Yes ☐ No	

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General anesthesia	Act. No. 352 December 22, 1999	A health plan that provides coverage for general anesthesia services, hospitalization services and dental services in the contract, shall not be able to exclude or deny coverage for general anesthesia to be administered by an anesthesiologist and hospitalization services when: (1) when a pediatric dentist, an oral or maxillofacial surgeon who is a member of the medical faculty of a hospital determines that the condition or ailment of the enrollee is significantly complex according to the criteria established by the American Academy of Pediatric Dentistry, (2) when the enrollee, because of his/her age, impediment, or disability, is unable to resist or tolerate pain, or cooperate with the treatment indicated in the dental procedures, (3) when the infant, boy, girl, adolescent, or person with a physical or mental impediment has a medical condition in which it is indispensable to carry out dental treatment under general anesthesia in an ambulatory surgical center or in a hospital, and that otherwise could pose a significant threat to the enrollee's health, (4) when local anesthesia is ineffective or contraindicated because of an acute infection, anatomic variation, or allergic condition, (5) when the enrollee is an infant, a boy, a girl, an adolescent, or a person with physical or mental disability, and is in a state of fear or anxiety that prevents performing the dental treatment under the procedure traditionally used in dental treatments and the condition is so critical that postponing or deferring treatment would result in pain, infection, loss of teeth, or dental morbidity, (6) when an enrollee has received an extensive and severe dental trauma where the use of local anesthesia would jeopardize the quality of the services or would be ineffective to handle the pain and apprehension. Preauthorization. Every carrier that requires preauthorization to provide the general anesthesia and hospitalization services coverage, as determined by a pediatric dentist, oral or maxillofacial surgeon, shall approve or deny it within two (2) days from the date the enrollee submits all the documents required by the carrier. The required documents shall be: (a) the enrollee's diagnosis; (b) the enrollee's medical condition; and (c) the reasons that justify for the enrollee to receive general anesthesia to perform the dental treatment.		
Federal Laws				
Mental Health Parity Act		The services provided under the contract regarding mental conditions must comply with the "Mental Health Parity Act". There shall be no distinction between a mental disorder and any other medical condition in terms of the access to the services that persons shall need. In addition, the contract may not include any limitations on visits to a psychiatrist, collateral visits, group therapy and residential treatments.		

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Circular and Rulings Letters				
OCS postal address	CC-2021-1979-D January 25, 2021	Direccion postal OCS Oficina del Comisionado de Seguros 361 Calle Calaf PO Box 195415 San Juan, PR 00919 Edificio World Plaza 268 Ave. Munoz Rivera San Juan, PR 00918		
SELECTION OF INDEPENDENT REVIEW ORGANIZATION	CC-2020-1977-D November 18, 2020	Independent External Reviews will be conducted through the independent review body "Maximus Federal Services, Inc".		
Billing Codes for diagnostic services, sampling and treatment of covid-19	CN-2021-292-D January 28, 2021	Billing Codes for diagnostic services, sampling and treatment of covid-19		
CODES AND FEES OF TESTING FOR THE DETECTION OF COVID-19	CN-2020-289-D December 11, 2020	Insurers and organizations are required to provide the health service providers and / or laboratories that administer tests for the diagnosis of COVID-19 within a term of five (5) days from the date of this Normative Letter. , the corresponding billing codes, sample collection codes, and fees for the molecular test, antigen test, and serological test, respectively.		
Personal Protective Equipment Cover for Dental Services	CN-2020-279-D June 16, 2020	Insurers and health care organizations are required to include the D1999 code on dental coverage for commercial health plans. The D1999 code must be billed by a dentist, under a current contract with an insurer or health services organization, accompanied by the dental procedure (s) performed per day and which are part of the patient's coverage, after their in-person visit to the dental office the rate corresponding to this code, which should not be less than $ 35.00 per face-to-face visit to the dental office		
AMENDMENT TO REGULATORY LETTER NO. 2020-274-D	CN-2020-278-D May 14, 2020	For the purpose of expanding its scope in accordance with the provisions of Joint Resolution 32-2020 and Law No. 48-2020. The provisions of Normative Letter CN-2020-274-D remain in force, as amended by what is established herein. the patient who receives medical or psychological attention through the use of telemedicine or telephone, will be exempted from paying shared costs for these services during the term of the Joint Resolution.		
PAYMENT TO HEALTH SERVICE PROVIDERS USE OF TELEMEDICINE	CN-2020-274-D April 8, 2020	All health services organizations and insurers that underwrite commercial health plans and Medicare Advantage honor the payment of services provided by health service providers, whether physical or mental health, through the use of telemedicine based on the same rate as if the service was provided in person face to face.		

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AMENDMENT TO REGULATORY LETTER NO. CN-2020-265-D	CN-2020-269-D March 20, 2020	Availability of coverage for the COVID-19 diagnostic test will be provided by insurers and health service organizations that subscribe to group and individual medical plans in the private sector "free of cost sharing" (including deductibles, copays and coinsurance) to the insured, in cases where the test is ordered to be performed in accordance with medical criteria. Neither may it establish prior authorization requirements or other service utilization management requirements.		
Access to Health Services	CN-2020-268-D March 16, 2020	Grace Period for Premium Payment, Medication Dispatch, Out-of-Network Providers, Pre-authorizations and Referrals, Telemedicine, Term for the presentation of claims		
GUIDELINES ON CARE FOR CORONA VIRUS (COVID-19)	CN-2020-265-D March 11, 2020	• Inform their insured on their internet portals and customer service telephone lines about the providers available to go to receive medical care services. • Allow free access to providers outside the network, in case of insufficient or unavailable providers • Provide coverage for emergency health services without prior authorization, regardless of whether the provider is a participant in your network. • Provide coverage, free of out-of-pocket cost to the insured (copayments, deductibles or coinsurance), for immunization services against COVID-19 • Rescind the requirement of pre-authorizations or step treatment, when for reasons of medical criteria a drug is recommended outside the formulary to treat any health condition associated with COVID-19		
Maximum Out of Pocket	Ruling Letter No. CN-2013-159-AS October 22, 2013	The Maximum Out of Pocket Limit (MOOP) that carriers should apply in their coverages, as established by the Commissioner, is $6,350 individual coverage and $12,700 family coverage.		
Meningitis vaccine	Ruling Letter No. 2011-131-AV September 1, 2011	Require that health plans must include the meningitis vaccine as part of the basic coverage.		
Preventive Services	Ruling Letter No. N-AV-7-8-2001 July 6, 2001	Requires every carrier to offer, as part of basic coverage, an annual medical evaluation that includes preventive services required by Act No. 296 of September 1, 2000 without any cost sharing beyond the premium originally established for said plans. The mentioned act imposes to the Puerto Rico Department of Education the responsibility to ensure that each child received an annual medical evaluation at the beginning of the school year. Said medical evaluation must include physical and mental evaluation, oral hygiene, hearing and visual tests, as well as periodic tests recommended by the American Academy of Pediatrics.		

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Hospital services	Ruling Letter No. N-AV-12-111-99 December 20, 1999	Requires that all carriers shall estipulate that in such cases in which an enrollee decides to use a private hospital room, instead of a semi-private room, he or she will be responsible for the difference in cost that this utilization represents. In addition, all health plans shall estipulate that unless in the cases of differences in the cost of the hospital rooms, the providers cannot charge to enrollees in a private rooms different quantities to those that have the rights to charge if said enrollee was confined in a semi-private room.		
HIPAA	Ruling Letter No. N-AV-10-90-97 November 24, 1997	Establishes that the Health Insurance Portability and Accountability Act (HIPAA) is applicable in our jurisdiction and preempts the Insurance Code, with regard to the provisions required in the act, which are not provided in said Code or which are less stringent than the federal requirements.		
Ambulance services	Ruling Letter No. N-C-8-71-95 October 13, 1995	Requires that all carriers that provides ambulance services in their coverage must estipulate that the ambulance companies that will render the services must be authorized by the Puerto Rico Commission of Public Services.		
HIV Screening	Circular Letter No. CC-2014-1848-AS January 22, 2014	Regarding pregnant women, all carriers are required to cover and will not impose cost-sharing requirements with regard to the following tests included in the most recent recommendations of the "United States Preventive Services Task Force (USPSTF): 1) A first HIV test during the first trimester of pregnancy at the first prenatal visit, and 2) A second test during the third trimester of pregnancy (between the 28th and 34th week of pregnancy).		

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Essential Health Benefits	Circular Letter No. 2013-1825-D March 1, 2013 and Section 2.050(D)(1) Health Code	All carriers that provide health plans to individuals and small groups, with the exception of grandfathered plans, large groups and large groups for Bona Fide Associations, will have to include in such plans at a minimum essential health services known as Essential Health Benefits (EHB). EHB include benefits and services in at least the following ten categories: 1. Out-patient (ambulatory) services and medical-surgical services 2. Emergency services 3. Hospitalization 4. Maternity and newborn care services 5. Mental health and substance use disorder services 6. Laboratories, X-Rays and diagnostic testing services 7. Pediatric services including the respiratory syncytial virus vaccine, the cervical cancer vaccine, the vision and dental care 8. Prescribed medication 9. Rehabilitation and habilitation services and equipment 10. Preventive, wellness, and management of chronic disease services 11. Any other mandatory service or benefit required by Commonwealth or Federal laws or regulations The EHB Benchmark Plan selected for Puerto Rico was Optimo Plus PPO. Exclusively with regard to pediatric vision services, the rule provides for using the coverage of the Federal Employees Dental and Vision Insurance Program (FEDVIP) to define the EHB that must be included in health plans.		
ADDITIONAL REQUIREMENTS				
Coordination of Benefit	Chapter 11 / Insurance Code § 11.110(1)	The contract shall include a coordination of benefit provision in compliance with the Coordination of Benefit Model Regulation of the NAIC.		
Medicare Supplement Policies disclosure notice	Rule L Regulation of the Insurance Code § 17(D)(1) Appendix C	Notice related to contracts or certificates which are not Medicare Supplement Policies. Disclosure Statements. Instructions for use of the disclosure statements for health plans sold to Medicare beneficiaries that duplicate Medicare.		

GOVERNMENT OF PUERTO RICO
OFFICE OF THE COMMISSIONER OF INSURANCE
PUERTO RICO FORM FILING CHECK LIST
SMALL GROUP MARKET

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Definitions		The contract has been revised to verify that all terms define in the same are actually being use.	☐ Yes ☐ No	
Table of Copayment, Coinsurance and Deductibles (Contract)		The Table of Copayment, Coinsurance and Deductibles of the contract include the cost sharing for all the covered services. This verification has been performed by the carrier.	☐ Yes ☐ No	
Providers Directory		The submission include the provided directory in the supporting documentation tab.	☐ Yes ☐ No	
Drug Formulary		The submission include the drug formulary by therapeutic category in the supporting documentation tab. The drug formulary include contraceptives for each of the types as approved by the FDA.	☐ Yes ☐ No	
Crime or Felony		Exclusions or limitations related to the commission or the attempt to commit a crime or felony clearly indicate that apply, except if any injury results from domestic violence or a medical condition.	☐ Yes ☐ No	
Service connected		Exclusions or limitations related to service connected injuries or conditions are not included. Language related to service connected injuries or conditions can be included in a Subrogation clause.	☐ Yes ☐ No	
Application Forms	Section 14.100 of the health insurance code Section 27.50 of the Insurance Code Rule 102 of the Regulations of the Insurance Code	If the application includes an authorization to disclose non-public personal health information, the authorization specifies the length of time the authorization will remain valid. The maximum allowable period is 24 months. The application contains the prescribed fraud warning statement above the insured's signature. The application contains a question requiring information with respect to other health insurance, for the Coordination of Benefits. If the health plan will be marketed by electronic means, the application must contain the required disclosures regarding the delivery of all policy documents, the right to obtain a paper copy free of charge and other applicable disclosures.	☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No	

Updated

CERTIFICATION

I _____ have reviewed or supervised the preparation of the above checklist and certify that the form(s) and/or drug formulary is (are) in compliance with all of the applicable requirements of the Insurance Code of Puerto Rico, Health Insurance Code of Puerto Rico, Federal and State Laws, Ruling and Circular Letters related to the Small Group Market, including Small Groups for Bonafide Associations, and that the form(s) and/or drug formulary does (do) not contain dispositions previously disapproved or required to be corrected by the Office of the Commissioner of Insurance of Puerto Rico. I also acknowledge responsibility for the validity, accuracy and completeness of the contents of this checklist, the transmittal letter and enclosures with the filing.

Signature: _____

Date: _____