

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

COMPANY: \_\_\_\_\_  
FORM(S) NUMBER: \_\_\_\_\_  
SERFF TRACKING NUMBER: \_\_\_\_\_  
TYPE OF INSURANCE (TOI) \_\_\_\_\_

ATTACHMENT 7A  
REVISED 02/2025

SUBJECT	REGULATORY REFERENCE	COMMENTS	Please specify location (Form/Page/Paragraph/ Other) of complying provision/language * <u>or attach explanation for a N/A response **</u>	FOR OFFICIAL USE ONLY
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.	<input type="checkbox"/> Yes <input type="checkbox"/> 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	Circular Letter CC-2015-1870-AV/AS	The cover letter include: a. A detailed explanation as to the purpose of the filing, and the intended use for each submitted form. b. The signature of a representative of the carrier, authorized to submit forms for filing or approval for the carrier. c. A description of any innovative or unique features of each form. d. 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. <b>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.</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No  <input type="checkbox"/> Yes <input type="checkbox"/> No	
Cover Letter	Rule XXIV	Brief, detailed description of benefits, purpose, and intended market. Disclose if form is new or replacement. If it is an amendment, endorsement or rider, the contract it will go with.	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Cover Letter	Rule XXIV	The cover letter include 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.	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Cover Letter	Rule XXIV	The cover letter advise whether or not the form is replacing a previously submitted form. If there have not been a substantial number of changes, submit a highlighted copy showing the material differences or changes made to the form. If the changes are too extensive, then a highlighted copy is not required, but the changes must be identified in the cover letter. State whether the previously submitted form was approved, disapproved, withdrawn or otherwise disposed or is still pending approval (under review) with the OCI and provide the form number and SERFF tracking number.	<input type="checkbox"/> Yes <input type="checkbox"/> No	

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Cover Letter		The cover letter indicate the SERFF tracking number of the filing where the rates applicable to the form(s) were submitted.	<input type="checkbox"/> Yes <input type="checkbox"/> 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.	<input type="checkbox"/> Yes <input type="checkbox"/> N/A <input type="checkbox"/> Yes <input type="checkbox"/> N/A	
Cover Letter		If a form is intended to replace a very recently approved form because of an error found in the approved form, and the approved form has not been issued, the carrier may request to make a substitution of the approved form using the regular prior approval process. The substitution request letter must confirm that the form has not been issued and identify the changes made to the corrected form. The carrier may, under these circumstances, use the same form number on the corrected form being submitted.	<input type="checkbox"/> Yes <input type="checkbox"/> N/A	
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.	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Variability (bracketed language)	§ 1111 § 1112 CC-2015-1869-AV/AS	Forms with variable bracketed information <b>must include all the possible language that might be placed within the brackets.</b> 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.	<input type="checkbox"/> Yes <input type="checkbox"/> N/A <input type="checkbox"/> Yes <input type="checkbox"/> N/A	
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.		
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.	<input type="checkbox"/> Yes <input type="checkbox"/> 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.	<input type="checkbox"/> Yes <input type="checkbox"/> 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.	<input type="checkbox"/> Yes <input type="checkbox"/> No	

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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.	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>CHAPTER 16 OF THE INSURANCE CODE OF PUERTO RICO (Insurance Code)</b>				
Chapter 16 Insurance Code	§ 1602(2)	The style, arrangement and overall appearance of the contract shall give no undue prominence to any portion of the text, and every printed portion of the text of the contract and of any endorsements or attached papers shall be plainly printed in light-faced type of a style in general use, <b>the size of which shall be uniform and not less than ten-point</b> with a lower case unspaced alphabet length not less than one hundred and twenty-point.	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Entire Contract	§ 1605	This provision must be included and must be no less favorable to the insured than the statutory provision.		
Grace Period	§ 1607	This provision must be included and must be no less favorable to the insured than the statutory provision.		
Reinstatement Provision	§ 1608	This provision must be included and must be no less favorable to the insured than the statutory provision.		
Notice of Claim Provision	§ 1609	<i>Only applicable for reimbursement purpose, the language must be adjusted accordingly.</i>		
Claim Forms Provision	§ 1610	<i>Only applicable for reimbursement purpose, the language must be adjusted accordingly.</i>		
Proof of Loss Provision	§ 1611	<i>Only applicable for reimbursement purpose, the language must be adjusted accordingly.</i>		
Time of Payment of Claims Provision	§ 1612	<i>Only applicable for reimbursement purpose, the language must be adjusted accordingly.</i>		
Payment of Claims Provision	§ 1613	<i>Only applicable for reimbursement purpose, the language must be adjusted accordingly.</i>		
Civil Actions Provision	§ 1615	Civil Actions Provision		
Misstatement of Age	§ 1622	<i>The language of the standard provision must be adjusted accordingly. The provision may read as follows: "If a subscriber's/insured's age has been misstated or incorrectly expressed, the premium will be adjusted to the correct age."</i>		
Order of Certain contract Provisions	§ 1629	The provisions which are the subject of §§ 1605-1628 of the Insurance Code, inclusive, or any corresponding provisions which are used in lieu thereof in accordance with such sections, shall be printed in the consecutive order of the provisions in such sections or, at the carrier option, any such provision may appear as a unit in any part of the contract, with other provisions to which it may be logically related, provided the resulting contract shall not be in whole or in part unintelligible, uncertain, ambiguous, abstruse, or likely to mislead a person to whom the contract is offered, delivered or issued.		

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Foster child definition	§ 1633	Family expenses disability - <i>Foster child definition</i> . The definition should not include any reference to lived under the same roof (residency) or be dependent to receive support (financial dependency).		
<b>HEALTH INSURANCE CODE OF PUERTO RICO (Health Code)</b>				
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, 10.030, 22.030, 24.030, 28.030, 52.030, 48.020 and 72.030 of the Health Insurance Code. Do not duplicate definitions. Definitions must be included as long as the contract uses the term. Also, if a same definition is included under more than one law, the definition must apply to the specific intention of each law.	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Dependent Coverage	§ 2.03(G) § 10.030(G)	If a contract offers dependent coverage, it must include dependent coverage until age 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) and 10.030(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:  (1) Services for adult, women and children with a rating of A or B as recommended by the U.S. Preventive Services Task Force. (2) Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention and the "Comité Asesor en Prácticas de Inmunización" of the Puerto Rico Health Department. (3) Preventive care and screenings for infants, children and adolescents as established in the guidelines supported by the Health Resources and Services Administration (HRSA). <b>(In Puerto Rico applies until 21 years).</b> (4) Preventive care and screenings for women as established in the guidelines supported by HRSA, including breast cancer screening, mammography and prevention.  Such coverage shall not be subject to deductibles, copayments, and/or coinsurance.  <b>The contract also include the link to access the current preventive services list.</b>		

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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. <i>(Only applicable to coverage managed through referrals and the designation of primary care provider is required)</i>		
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. <i>(Only applicable to coverage managed through referrals and the designation of primary care provider is applicable)</i>		
Pre-existing Conditions	§ 2.050(I) § 10.050(M)	No individual health plan shall deny, exclude or limit the benefits of an enrollee based on preexisting conditions, regardless of the age of the enrollee.		
Rescission	Chapter 2 / Health Insurance Code § 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.	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Changes to the formulary	Chapter 4 / Health Insurance Code § 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	Chapter 4 / Health Insurance Code § 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.  <b>The language of this section must be included in the contract in the same format and order established in Section 4.070.</b>		

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Disclosure	Chapter 4 / Health Insurance Code § 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	Chapter 4 / Health Insurance Code § 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.		
Guaranteed renewability	Chapter 10 / Health Insurance Code § 10.060	An individual health plan shall be renewable or shall continue in force the coverage for the enrollee and his/her dependent, at the option of the enrollee.  Guaranteed renewability. A carrier must renew or continue in force the coverage at the option of the individual, except for nonpayment of premium, fraud, termination of product and movement outside the service area.		
Availability of coverage	Chapter 10 / Health Insurance Code § 10.080	The contract must include a clause establishing the availability of coverage in the Individual Market in compliance with Section 10.080.		
Qualifying events	Chapter 10 / Health Insurance Code § § 10.150(C) and (D)	The contract must establish the events in which an individual can obtain coverage due to a qualified event as describe in Section 10.150 of the Health Code and Ruling Letter CN-201-156-AS of September 30, 2013.		
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.		
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.  <b>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.</b>		
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.  <b>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.</b>		

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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. <i>(Only applicable to manage care plans)</i>  <b>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.</b>		
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.  <b>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.</b>		
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,  <b>The title and language of the provision must be included in the form in the same format and order established in Section 24.090.</b>		
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.  <b>The title and language of the provision must be included in the form in the same format and order established in Section 24.100.</b>		
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.  <b>The title and language of the provision must be included in the form in the same format and order established in Section 24.110.</b>		
Disclosure Requirements	Chapter 24 / Health Insurance Code § 24.130(B)	Health insurance organizations or insurers will include a summary of your utilization review procedures and determination of benefits in the materials delivered to the potential covered or insured persons. <b>(The insurer must provide evidence of compliance with this disposition.)</b> (the PDF document must be identified as "Evidence Compliance 24.130(B)")		
Disclosure Requirements	Chapter 24 / Health Insurance Code § 24.130(C)	Health insurance organizations or insurers will print, on the medical plan card of the covered or insured person, a toll-free telephone number that can be called to obtain information on the determinations of the procedures of utilization review and benefit determination. <b>(The insurer must provide evidence of compliance with this disposition.)</b> (the PDF document must be identified as "Evidence Compliance 24.130(C)")		

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Creation of Adequate network	Chapter 26 / Health Insurance Code § 26.050	health insurance organizations or insurers shall file with the Commissioner an access plan that meets the requirements set forth in this Chapter for each of the coordinated care plans offered in P.R.		
Requirements for health insurance organizations, insurers and in-network providers	Chapter 26 / Health Insurance Code § 26.060	Provide evidence of compliance with this chapter and of the provisions of the contract between issuer and in-network provider.		
Filing Requirements	Chapter 26 / Health Insurance Code § 26.080	The health insurance organizations or insurers will file with the Commissioner the model contracts that they will use with their participating providers and intermediaries, so that the Commissioner can verify compliance with the provisions of this Chapter.		
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.  <b>The title and language of the provision must be included in the form in the same format and order established in Section 28.050.</b>		
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.  <b>The title and language of the provision must be included in the form in the same format and order established in Section 28.060.</b>		
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.  <b>The title and language of the provision must be included in the form in the same format and order established in Section 28.070.</b>		
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.  <b>The title and language of the provision must be included in the form in the same format and order established in Section 28.080.</b>		
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.  <b>The title and language of the provision must be included in the form in the same format and order established in Section 28.090.</b>		

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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.  <b>The title and language of the provision must be included in the form in the same format and order established in Section 28.100.</b>		
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.		
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.  <b>The title and language of the provision must be included in the form in the same format and order established in Section 28.170.</b>		
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.  <b>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).</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.  <b>The language of this section must be included in the contract in the same format and order established in Section 54.060(A).</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.		
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;.		
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;		
No Surprised Bills	Chapter 48 / Health Insurance Code § 48.050(B3)	3. examples of anticipated costs for services out-of-network frequently billed		

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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;		
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;		
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.		
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.		
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.		

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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.		
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.  <b>The language of this section must be included in the contract in the same format and order established in Section 54.050(B).</b>		
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.  <b>The language of this section must be included in the contract in the same format and order established in the Section 72.040(A).</b>		
<b>OTHER REQUIREMENTS FOR HEALTH SERVICES ORGANIZATIONS</b>				
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.	<input type="checkbox"/> Yes <input type="checkbox"/> 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. <b>The terms "insurer", "insured", "insurance", "insurance company", "policy", "insure" cannot be use.</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	

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<b>Puerto Rico Laws</b>				
New Chapter 54 Insurance Code of Puerto Rico - Third Party Administrator	Act No. 169 August 26, 2024 Chapter 54 Insurance Code of Puerto Rico	No person shall act as a Third Party Administrator in the Commonwealth of Puerto Rico unless he or she holds a license to do so issued by the Commissioner in accordance with this Chapter and applicable regulations, unless such person is exempt from the authorization requirement pursuant to Section 54.110, paragraph G of this Chapter. This prohibition shall not apply to a person while employed by or when contracted by a Third Party Administrator who holds a license under this Chapter or is exempt from the authorization requirements pursuant to Section 54.110, paragraph G of this Chapter.  <i>(All health plan issuers that have contracts with third-party administrators must report the names of said third parties and present evidence of the license issued by the OCS or the exemption.)</i>		NEW
Amend the Bill of Rights for Patients and Survivors of Cancer	Act No. 165 August 15, 2024	(g) Insurers may not reject or deny any treatment that is agreed upon or that is within the terms and conditions of the health contract signed between the parties, when there is a medical recommendation for such purposes and it is based on the National Comprehensive Cancer Network Guidelines or those approved by the Food and Drug Administration. Physicians, health service organizations, insurers, administrators, managers or contracted third parties and providers may not reject or deny treatment, including hospitalization, diagnosis and medication, to any patient diagnosed with cancer. The diagnosis and treatment recommended and established by the medical professional will be the governing and exclusive criterion to determine the treatment to be followed in a patient. The professional medical criterion may not be altered without the endorsement of the physician or the patient, as the case may be. However, this section must comply with federal laws and regulations on the subject. For the cancer survivor, the frequent and ongoing treatment and monitoring of the insured's physical health and emotional well-being cannot be left uncovered by said insurers, administrators, managers or contracted third parties, health service organizations and health care plan providers.		NEW
Autism Spectrum Disorder	Act No. 163 August 13, 2024 (Law 220-2012, as amended, is hereby repealed)	All health plans will be required to offer coverage for all health interventions scientifically validated as effective for Autism Spectrum Disorders. These coverages should include, but are not limited to, services aimed at diagnosis and intervention such as: genetics, neurology, psychiatry, immunology, gastroenterology, endocrinology and nutrition; speech and language, psychological, psychiatric, occupational, visual, auditory, physical, feeding and dysphagia, behavioral evaluations and therapies, including "Applied Behavior Analysis" (ABA), or others based on the corresponding evaluations and based on evidence, which will include medical visits, tests referred with the necessary accommodations, including priority appointment, anesthesia and other medical services that are medically necessary for the treatment of patients with autism. Without limitation, laboratory tests, electroencephalogram, magnetic resonance imaging (MRI) among other radiological tests that are medically necessary, dental work, among other services that are medically recommended due to the complexity of managing anxiety and behavior of patients with autism. The coverage for these purposes may not establish limitations regarding the age of the patients. Nor may it be subject to a benefit limit or a cap on the number of visits to a medical services professional, after the medical		NEW
Authorized collective bargaining	Act No. 78 May 16, 2024 Section 31.030... Insurance Code of Puerto Rico	The rates to be charged to the premium of medical plans shall be subject to the review standards and rate restrictions provided in Articles 8,050, 10,050 and 16,100 of Act 194-2011, as amended, as well as Article 19,080 of this Code. If the negotiation between the parties involved results in an increase in the deductible or copayment, premium or rate, the insurer or health services organization must submit to the Insurance Commissioner and obtain authorization for such increase, prior to it taking effect in accordance with the ordinary procedures for annual review and approval of medical plan rates under this Code and the Puerto Rico Health Insurance Code.		NEW

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Hereditary Angioedema coverage	Act No. 62 April 16, 2024	<p>Health plans must include the condition of Hereditary Angioedema in their coverage.</p> <p>These coverages will establish, without being understood as a limitation, direct access to providers and specialist doctors, as well as those medications, treatments, therapies and tests that are not experimental or genetically modified, scientifically validated as effective and recommended to diagnose and treat the condition of Hereditary Angioedema according to the specific needs of the patient, without the need for a referral.</p> <p>All health plans will hire specialists who treat the condition of Hereditary Angioedema if they do not have them as part of their provider network, or, in the alternative that they do not have them contracted, require the patient to pay the cost of the service of an out-of-network provider for reimbursement as if the specialist belonged to the provider network of the health plan.</p> <p><i>(The drug formulary must be revised to include the following class of medications on your drug formulary to comply with Act 62-2024 Hereditary Angioedema: "Hereditary angioedema agents.")</i></p>		NEW
Eliminate referral requirements to chronic disease beneficiaries	Act No. 28 January 18, 2024 Section 2.050(I) Health Insurance Code	<p>I. No individual or group medical plan may require a referral for those beneficiaries who suffer from chronic or high-cost diseases, as defined by the Department of Health and in this Article. For the purposes of that subsection, will consider a chronic disease to be that which is usually</p> <p>It develops slowly, tends to have a long duration, and its severity progresses over time. It can be controlled, but it is rarely cured. For its part, a high-cost disease will be understood as one with a similar impact to chronic disease, but with the difference that it does not necessarily progress if it is treated and controlled in time.</p>		
Lab test without medical order	Act No. 29 January 18, 2024	<p>Article 9.- Rights - Participation in making decisions about treatment.</p> <p>Every patient, user or consumer of medical-hospital health services in Puerto Rico has the right to (i) request the services of a clinical laboratory and require that it be</p> <p>offer the following clinical tests, which will be exempt from the requirement of presentation of a medical order, as long as the patient defrays the costs of the tests performed: fasting glucose, qualitative pregnancy test, progesterone, complete blood count , comprehensive metabolic panel, glycosylated hemoglobin, urinalysis, urine culture, urine microalbumin, fecal occult blood, prostate-specific antigen, hepatitis, lipid and thyroid panels, tests for the detection of acquired immunodeficiency virus, tests for detection of syphilis, gonorrhea, chlamydia, influenza, mycoplasma, mononucleosis and herpes simplex, tests for prothrombin and thromboplastin clotting time, hemocysteine, vitamins B12 and D and C-reactive protein (qualitative and quantitative), tests for detection of COVSARS-2 , respiratory syncytial virus (RSV) and any other test classified as exempted by the Food and Drug Administration (FDA). The results delivered by the clinical laboratory to the patient must indicate the following: "The results must be interpreted and consulted by a licensed physician for the protection of the patient."</p>		
Uniform and Coordinated Multisectoral Stroke Management System	Act No. 121 October 30, 2023	<p>It is established that it is essential and essential that health insurance organizations within the Government Health Plan, as well as those authorized by the Office of the Insurance Commissioner to do business in Puerto Rico, or their intermediaries or third-party administrators within the public or private plans, establish adequate compensation rates for payment for the services provided by hospital facilities and health professionals who provide services under the State Plan and the Uniform Protocol required by this Law within the identification, diagnosis , management, transportation and prehospital treatment and post-hospital care of patients who suffer an event of stroke covered by them. Therefore, as part of the health system within the jurisdiction of Puerto Rico, it is It is essential and necessary that the services provided by the designated and certified hospital facilities, health professionals, health providers and operational components within them be compensated and paid on time and in compliance with the public policy of this Law so that the itself can be functional.</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No	

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Prevention, detection and effective treatment of postpartum depression	Act No. 101 August 30, 2023	Without prejudice to reasonable and lawful deductibles, all insurers and organized health service organizations comply with Law No. 77 of June 19, 1957, as amended, known as the "Puerto Rico Insurance Code," insurance plans that provide services in Puerto Rico and any other entity contracted to offer health benefits in Puerto Rico, as well as the Government Health Plan, will expressly cover, in all their products, plans or premiums, the screening and physical and emotional treatment of mothers who reflect symptoms of prepartum or postpartum depression, or who are identified or referred to professionals or emotional health institutions as patients at risk of suffering from it.		
To include discounts, coupons or contributions by drug manufacturer in the calculation of the cost sharing requirements.	Act No. 109 August 31, 2023 Section 4.050 Health Insurance Code	Any health insurance organization or insurer that provides prescription drug benefits, pharmacy benefits manager or administrator, contracted third party or any entity to which the administration or management of pharmacy services or benefits has been delegated, will include in the calculation or requirement of the contribution or cost sharing ("cost sharing, out of pocket maximum") 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, coinsurance, deductible or in compliance with shared contribution requirements. These contributions, discounts and coupons from the manufacturer will be available and can be used at all health providers, in accordance with the program requirements, regardless of the place of acquisition of the discount or coupon. The use of the benefit accumulator, maximizer or any other similar program that has the effect of implementing a restriction or limitation on the liability established in this subsection is prohibited.		
Uniform Application Form - Credentialing and Re-credentialing	Act No. 73 July 17, 2023 Sections 18.040, 18.051, 18.052, 18.053 Health Insurance Code	In order to establish uniformity in the information and documents required for credentialing and re-credentialing as provided in subsection (a) of this Section, the Secretary of the Department of Health, in coordination with the Office of the Commissioner of Insurance, will adopt a Uniform Application Form for Credentialing and Re-credentialing, in electronic format, which will be used in the credentialing and re-credentialing processes of care management organizations and insurers that are authorized by contract with the Administration for the management of the Health Plan of the Government, in accordance with the parameters promulgated by or the Centers for Medicare and Medicaid Services	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Coverage for Screening and Diagnosis of Hepatitis A, B, and C	Act No. 67 June 12, 2023	Any medical plan, coverage, policy or contract for health services, or its equivalent in Puerto Rico, whether public or private, offered by any health insurance organization or insurer authorized by the Office of the Insurance Commissioner to provide health insurance services. in the Commonwealth of Puerto Rico, will offer within its basic coverage a screening test for the Hepatitis A, Hepatitis B and C (HCV) virus per year, as well as the sequence of tests in case of reactive antibody tests, as part of routine studies of all medical evaluation; except that, for people with recognized conditions or exposures, they should be covered according to the frequency provided in the current recommendations of the Centers for Disease Control and Prevention – this will include one test mentioned in this Article for pregnant people for each pregnancy. The type, sequence and frequency of tests to be covered will be in accordance with the recommendations of the Centers for Disease Control and Prevention.		

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Persons under the age of twenty-one (21) years of age, bedridden with complex physical or physiological diversities	Act No. 40 February 21, 2023 Section 19.030(5) Insurance Code	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, persons under the age of twenty-one (21) years of age, bedridden with complex physical or physiological diversities and people who require a ventilator to stay alive, a minimum of a daily shift of eight (8) hours of nursing staff; or duly licensed emergency medical technicians-paramedics (TEM-P). In addition, emergency medical technicians-paramedics (as) (TEM-P) duly licensed (as) 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 their medical equipment according to authorized in this Law		
Bill of Rights and Responsibilities of People Living with Diabetes	Act No. 14 January 12, 2023	Article 6.- Right to social justice - People living with diabetes have the right to: e) not be discriminated against when making a request for health insurance coverage;	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Coverage for Albinism and Hermansky-Pudlak Syndrome	Act No. 109 December 22, 2022	Private health plans must include in their special coverage the condition of albinism and the genetic disorders that can cause it. Provide for direct access to providers and specialist doctors, as well as those medications, treatments, therapies and tests that are not experimental or genetically modified, scientifically validated as effective and recommended to diagnose and treat the condition, without the need for a referral. Coverage must include the cost of HPS type 1 genetic testing. a. Medically necessary follow-up services, tests and procedures by an ophthalmologist or dermatologist for the management of the condition once the diagnosis is established;  b. In cases of Hermansky-Pudlak and Chediak-Higashi Syndrome, the services, tests and procedures offered by a hematologist will also be covered;  c. Medications prescribed by: ophthalmologists, dermatologists and in cases of Hermansky-Pudlak Syndrome, those prescribed by hematologists, pulmonologists to treat conditions or complications in the management and prevention of complications in this population;  d. Lenses and eyeglasses specially prescribed for protection, prevention and improvement of vision, according to the quantity and cost parameters established by the Government Health Plan;  and. Specific sun protection creams to prevent complications due to exposure to ultraviolet rays, according to the quantity parameters to be offered within the coverage by the Government Health Plan. These lotions or creams must offer at least an SPF sun protection factor of 50 or more and protect against ultraviolet A and B rays (UVA and UVB); and  F. Any other service, treatment or medication that the Health Insurance Administration deems appropriate to include.		
Down Syndrome amendment	Act No. 13 March 25, 2022	Clarify its scope. The cover must be from birth. Therapeutic services with a remedial approach shall include, but shall not be limited to, physical therapies, speech therapies, occupational therapies, and any other necessary therapy recommended by a health professional authorized to practice such profession in Puerto Rico or the United States, in the quantities and frequency prescribed by the professional or specialist.		

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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		
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: <b>(n) "Health Professional"</b> – 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.		
Psicologist uniform definition	Act No. 79 December 30, 2021  Section 1	<b>q) “Psychologist”</b> - 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.		
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.”		
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.		

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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		
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 Determinations 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	<p>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.</p> <p>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.</p> <p>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.</p>		
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	<p>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.</p> <p>*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.</p>		

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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.”  <b>Ruling Letter No. CN-2016-209-AS:</b> 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.		
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.		

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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 Públicos), attached to the Puerto Rico Public Service Regulatory Board (Junta Reglamentadora de Servicio Público de Puerto Rico). Law 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.		
HIV/AIDS Virus	Act No. 248 December 1, 2018	Every person living with HIV at any stage has the right to: health protection, assistance, health care and appropriate treatment. These people will receive clear, accurate and scientific information about HIV infection at all stages, including the AIDS stage (the most advanced stage of infection), without any type of restriction. They also have the right to receive specific information about their health status, laboratory results and appropriate drug treatment options.		
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 <b>Preparation</b> " for enrollees diagnosed with the genetic disorder called phenylketonuria (PKU), with no enrollee age exclusions.  <b>This mandatory coverage is in addition to the recommended preventive service of screening for the genetic disorder (PKU) in newborns.</b>		
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.		
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.		

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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.	Amended by Law 163-2024	
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.		
Bariatric surgery	Act No. 212 August 9, 2008	<p>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.</p> <p>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).</p> <p>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.</p>		

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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 <i>naturopathic physician</i> , 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.		
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	

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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.		
Extension of Benefits	Act No. 194 August 25, 2000 Section 7(b)	<p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p>		

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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.		
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.		
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.		

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General anesthesia	Act. No. 352 December 22, 1999	<p>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:</p> <p>(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,</p> <p>(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,</p> <p>(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,</p> <p>(4) when local anesthesia is ineffective or contraindicated because of an acute infection, anatomic variation, or allergic condition,</p> <p>(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,</p> <p>(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.</p> <p>Preauthorization.</p> <p>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:</p> <p>(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.</p>		
<b>Federal Laws</b>				
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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<b>Circular and Rulings Letters</b>				
Fase I of Implementation of digital platform for credentialization of providers	CC-2025-2044-D January 9, 2025	To inform Fase II of the implementation of the platform for credentializing and recredentializing health providers		NEW
OCS Postal Address	CC-2024-2037-D May 20, 2024	Oficina del Comisionado de Seguros PO Box 195415 San Juan PR 00919-5415		NEW
Cibersecurity Rules for Insurance Industry	CN-2024-362-D November 7, 2024	Compliance with the dispositions of Rule 108 - Cibersecurity Rules for Insurance Industry		NEW
Administrative Order num. 594 Health Department Hepatitis A, B C	CN-2024-360-D September 6, 2024	Obligation of All Health Services Organizations and Insurers that sign up for Medical Plans In Puerto Rico to comply with Law No. 67-2023 and Administrative Order No. 594.		NEW
Providers Network Audits	CN-2024-356-AV May 3, 2024	Every insurer must provide on or before March 31 each year a copy of the provider network audit by an independent private audit firm.		NEW
Uniform Rules about coverage of diagnostic and treatment of Cancer survivor patient	CN-2024-347-D February 22, 2024	Establish the rules for Cancer coverage pursuant to Law 79-2020, Law 275-2012, Law 107-2012 and Law 10-2020.		
Obligation to provide COVID-19 treatments and tests; Mandatory immunization coverage	CN-2024-346-D February 14, 2024	Circular letter No. 2024-004 Health Department - and Law 43-2020 establish the obligation of all health services organization that administers a plan of public or private health, to provide treatments, medicines and diagnostic tests to the patients with COVID-19 symptoms.		
Obligation to provide Influenza treatments and tests; Mandatory immunization coverage	CN-2023-343-D November 9, 2023	Administrative Order No. 2023-579 - establish the obligation of all health services organization that administers a plan of public or private health, to provide treatments, medicines and diagnostic tests to the patients with influenza symptoms.		
Fase I of Implementation of digital platform for credentialization of providers	CC-2023-2020-D September 20, 2023	To inform the start of the implementation of the platform for credentializing and recredentializing health providers		
Independent Review Organization - Arbitration - NoSurprised Act	CC-2023-2017-D September 15, 2023	Selection of the Independent Review Organization for External Review Process and Arbitration Process in No surprised act - Chapters 28 and 48 Health Insurance Code		
Uniform Application Form - Credentializing	CN-2023-339-D August 17, 2023	Implementation of Uniform Application Form for Credentializing		
Without effect Law 142-2020	CN-2023-337-AS June 14, 2023	Amend Ruling letter CN-2023-332-AS in light of Federal Court Decision		
End of Emergency State COVID-19	CN-2023-335-D May 12, 2023	Executive Order OE-2023-12 of May 11, 2023 - End of the Emergency State - COVID-19		
Obligation to provide Influenza treatments and tests; Mandatory immunization coverage	CN-2022-325-D November 18, 2022	Administrative Order No. 554 - establish the obligation of all health services organization that administers a plan of public or private health, to provide treatments, medicines and diagnostic tests to the patients with influenza symptoms.		

\* Page number range are not accepted (i.e. 28-32)

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

SUBJECT	REGULATORY REFERENCE	COMMENTS	Please specify location (Form/Page/Paragraph/ Other) of complying provision/language * <u>or attach explanation for a N/A response **</u>	FOR OFFICIAL USE ONLY
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.		
Hospital services	Ruling Letter No. N-AV-12-111-99 December 20, 1999	Requires that all carriers shall stipulate 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 stipulate 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 stipulate that the ambulance companies that will render the services must be authorized by the Puerto Rico Commission of Public Services.		

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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).		
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.		
<b>ADDITIONAL REQUIREMENTS</b>				
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.		

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Definitions		The contract has been revised to verify that all terms define in the same are actually being use.	<input type="checkbox"/> Yes <input type="checkbox"/> 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.	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Providers Directory		The submission include the provided directory in the supporting documentation tab.	<input type="checkbox"/> Yes <input type="checkbox"/> 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.	<input type="checkbox"/> Yes <input type="checkbox"/> No  <input type="checkbox"/> Yes <input type="checkbox"/> 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.	<input type="checkbox"/> Yes <input type="checkbox"/> 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.	<input type="checkbox"/> Yes <input type="checkbox"/> 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, <b>amended by Rule 110</b>	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.	<input type="checkbox"/> Yes <input type="checkbox"/> No          <input type="checkbox"/> Yes <input type="checkbox"/> No          <input type="checkbox"/> Yes <input type="checkbox"/> No	

**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 Individual Market 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: \_\_\_\_\_

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