

Form Filing Review Checklist
HEALTH SERVICES PLANS
(LARGE GROUP)

NOTICE: A health insurance product form filing submission must include: (i) a product-specific checklist, and (ii) a mental health and substance use disorder benefits parity checklist. Each required checklist must be completed in its entirety. The failure to submit a completed checklist will result in a delay of the review of the submission, and may result in the rejection of the filing.

This document is intended to assist carriers in preparing form filings for approval by the Bureau of Insurance. It provides guidance based on current Virginia laws and regulations. It should be noted, however, that this checklist should not be used exclusive of other important resources, including, but not limited to, any and all other applicable state insurance laws and associated rules and regulations. It is the responsibility of the carriers to verify that their products and plans comply with all relevant statutory and regulatory requirements. Note that some regulatory references in the comments column are approximate. Please review the applicable citation for the full text of the requirement.

The Life and Health Division, Forms Section will review submissions based on the requirements noted in this checklist. Please contact this Section at (804) 371-9110 if you have questions or need additional information about these requirements.

Company Name:	
Product Name:	SERFF Tracking Number:

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HEALTH SERVICES PLANS
(LARGE GROUP)

REVIEW REQUIREMENTS	FEDERAL AND/OR VIRGINIA CITATION	COMMENTS	PAGE NO.
General Filing Requirements			
	14 VAC 5-100-40 1	Each form submitted must have a number which may consist of digits, letters or a combination of both. The number must distinguish the form from all other forms used by the insurer.	
	14 VAC 5-100-40 3	Certificate of Compliance signed by General Counsel or officer of company, or attorney or actuary representing company is required.	
	14 VAC 5-100-40 5	Description of market for which the forms are intended.	
Form Number	14 VAC 5-100-50 1 § 38.2-3500 A 5	Form number must appear in lower left-hand corner of first page of each form.	
Company Name & Address	14 VAC 5-100-50 2	Full and proper corporate name (including "Inc." or "The") and address must prominently appear on cover sheet of all policies and other forms required to be submitted.	
Final form	14 VAC 5-100-50 3	Form must be submitted in the form in which it will be issued and completed in "John Doe" fashion to indicate its intended use.	
Application	14 VAC 5-100-50 4	Any form, to be issued with an attached application, must be filed with a copy of the application completed in "John Doe" fashion to indicate its intended use. (If an application was previously approved, provide SERFF tracking number or copy with approval date.)	
Type Size	14 VAC 5-100-50 5	All forms must be printed with a type size of at least eight-point.	
Additional SERFF Filing Requirements	<i>Administrative Letter 2012-03</i>	<i>Additional SERFF filing requirements must be met as specified below for life and health forms and rate filings. Failure to provide the applicable information may result in a "REJECTED" filing.</i>	
General Information – Filing Description		(i) Description of each form by name, title, edition date, and intended use.	
		(ii) Identification of changes in benefits and premiums (previously approved or filed forms). [Place changed contract provisions (red-lined or highlighted) in Supporting Documentation].	
		(iii) Identification of SERFF or state tracking number for the previously approved or filed form for which the new form revises, replaces, or is intended to be used.	
		(iv) A statement as to whether any other regulatory body has withdrawn approval of the form because the form contains one or more provisions that were deemed to be misleading, deceptive or contrary to public policy.	

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MCHIP Requirements			
		<p>Regarding the plan submitted with this filing, is the provider network consistent with the information previously filed and approved under Section 38.2-5802? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If no, this filing must include the following:</p> <ol style="list-style-type: none"> 1. A detailed description of the criteria used to determine how a provider is included in the network or allocated to a tier within the network. 2. An explanation of whether or not the network change or tiered network will result in any material change in the method of operation that is currently on file with the Financial Regulation Division. <p>Pursuant to Administrative Letter 1998-11, any change that increases or decreases, or is likely to increase or decrease a health carrier's revenues, expenses, or net worth in an amount that exceeds 5% of the health carrier's current net worth qualifies as a material change that must receive prior approval from the Financial Regulation Division.</p> <ol style="list-style-type: none"> 3. A response as to whether or not the Virginia Department of Health (VDH) has determined that the network is adequate. 	
Provider Lists	§ 38.2-5803 A 1	List of providers and their locations shall be available to the enrollee. If an electronic version is made available, the coverage document must include a direct workable URL so that the insured can access the specific provider directory applicable to that particular plan. The insured must not be required to log in to access this information, and must be provided all information necessary to determine the applicable provider network.	
Service Area	§ 38.2-5803 A 2	Description of service area or areas shall be described in the policy.	
Complaints	§ 38.2-5803 A 3	Description of method of resolving complaints.	
Bureau of Insurance & Department of Health Notice	§ 38.2-5803 A 4	Each EOC shall contain a notice: "This Company is subject to regulation in this Commonwealth by the State Corporation Commission Bureau of Insurance pursuant to Title 38.2 and by the Virginia Department of Health pursuant to Title 32.1."	
Ombudsman Notice	§ 38.2-5803 A 5	A prominent notice in the EOC stating: "If you have any questions regarding an appeal or grievance concerning the health care services that you have been provided which have not been satisfactorily addressed by your plan, you may contact the Office of the Managed Care Ombudsman for assistance." Such notice must also include the toll free telephone number, mailing address and electronic mailing address of the Office of the Managed Care Ombudsman.	
General Provisions			
Contents of Policies/Important Notice	§ 38.2-305 A & B	Each policy shall specify: (1) names of parties to contract, (2) subject of insurance, (3) risk insured against, (4) time the insurance takes effect and period during which insurance is to continue, (5) conditions pertaining to insurance. Policy must also contain an important notice regarding who to contact with questions.	

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Insurance Fraud Notice Not Applicable	§ 38.2-316 D 1	Any notice citing Code of Virginia § 52-40 defining insurance fraud and penalties associated with this section must be removed. This section does not apply to accident and sickness insurance.	
Misrepresentation	§ 38.2-316 D 3	No form shall contain any provision that encourages misrepresentation or is misleading, deceptive or contrary to the public policy.	
Nondiscrimination	§ 38.2-508 2	Plan may not unfairly discriminate or permit any unfair discrimination between individuals of the same class and of essentially the same hazard (i) in the amount of premium, policy fees, or rates charged for any policy or contract of accident or health insurance, (ii) in the benefits payable under such policy or contract, (iii) in any of the terms or conditions of such policy or contract, or (iv) in any other manner.	
Medicaid Eligibility/Status Prohibited	§ 38.2-508.3	When considering eligibility, Medicaid eligibility cannot be a factor, and when determining a claim, Medicaid status cannot be a factor.	
Subrogation	§ 38.2-3405 A	Policy cannot allow subrogation of any person's right to recovery for personal injuries from a third party.	
COB/Liability Coverage Prohibited	§ 38.2-3405 B	No plan shall require the beneficiary to pay back any benefits from the proceeds of a recovery by such beneficiary from any other source. This provision shall not prohibit an exclusion of benefits paid under workers' compensation laws or govt. programs nor shall it prohibit coordination of benefits between insurance contracts.	
Workers' Compensation Exclusion	§ 38.2-3405 D	Under specified circumstances, issuers shall not exclude coverage for any medical condition whenever benefits payable under workers' compensation are excluded from coverage.	
Denial of Certain Prescription Drugs Prohibited	§ 38.2-3407.5	Each EOC must contain language indicating benefits will not be denied for any drug approved by the USFDA to treat (i) cancer because the drug has not been approved by the USFDA for that specific type of cancer for which the drug has been prescribed, or (ii) a covered indication if the drug has been approved by the USFDA for at least one indication, if the drug is recognized in standard reference compendia as safe and effective for treatment of that specific type of cancer, or that covered indication, respectively.	
Prescription Contraceptives	§ 38.2-3407.5:1	Plan that contains coverage for prescription drugs must offer coverage for prescribed contraceptive drugs & devices approved by the USFDA.	
Denial of Benefits for Certain Prescription Drugs Prohibited	§ 38.2-3407.6:1	Each EOC must contain language indicating benefits will not be denied for any FDA approved drug to treat cancer pain because the dosage is in excess of recommended dosage, if prescribed for a patient with intractable cancer pain.	
Ambulance Services	§ 38.2-3407.9	A covered person must not be required to obtain prior authorization for ambulance services and must not be directed to use any system other than an emergency 911 system or other state, county or municipal emergency medical system for ambulance services.	

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Prescription Drug Formularies	§ 38.2-3407.9:01 B 1, 2, 3	For plans using closed formularies, plan must have a process to allow medically necessary non-formulary prescription drug if the formulary drug is determined by the health services plan and physician to be inappropriate therapy. Requests must be acted on within one business day of receipt. See specific subsections of the Code.	
Exclusion of Prescription Drug Coverage Prohibited	§ 38.2-3407.9:02	Prescription drugs shall not be excluded from coverage solely on the basis of the length of time since the drug obtained FDA approval.	
Provider Continuation – Active Treatment	§ 38.2-3407.10 F 1	Terminated provider may continue to treat enrollee for 90 days, if enrollee is under active course of treatment with provider, enrollee requests such continuing care, and provider has not been terminated for cause.	
Provider Continuation – Pregnancy	§ 38.2-3407.10 F 2	Terminated provider may continue to treat enrollee, who has entered 2 nd trimester of pregnancy at the time of provider's termination, except when provider is terminated for cause. Treatment may continue through postpartum care.	
Provider Continuation – Terminal Illness	§ 38.2-3407.10 F 3	Terminated provider may continue to treat enrollee who is determined to be terminally ill at the time of provider's termination, except when the provider is terminated for cause. Treatment may continue for duration of enrollee's life for care of terminal illness.	
Reduction of Benefits	§ 38.2-3407.10 M	Carriers shall provide group policyholders written notice of any benefit reductions. Policyholders shall provide employees written notice of benefit reductions.	
Access to Obstetricians/ Gynecologists	§ 38.2-3407.11	Policies that include coverage for obstetrical or gynecological services shall permit any covered female of age thirteen or older direct access, as provided in this section of the Code, to the health care services of a participating obstetrician-gynecologist (i) authorized to provide services under the policy, contract or plan and (ii) selected by such female.	
Access to Specialists- Standing Referrals	§ 38.2-3407.11:1	The plan must permit any enrollee a standing referral as provided in subsection B of this statute.	
Standing Referrals for Cancer Patients	§ 38.2-3407.11:2	The plan must place a procedure in place to permit an enrollee diagnosed with cancer to have a standing referral to a board-certified physician in pain management or oncologist authorized to provide services.	
Breast Cancer Underwriting and Preexisting Conditions Restrictions	§ 38.2-3407.11:3	Plan is prohibited from denying the issuance or renewal of coverage, or from canceling such coverage, or from including the exception or exclusion of benefits based solely on the members having a high risk of breast cancer or having had breast cancer, and having been cancer free for 5 years or more.	
Coordination of Benefits: Notice of Primary Coverage	§ 38.2-3407.13:1	COB provision shall be prominent in enrollment materials.	
Claims Paid to Insureds for Services from Nonpar. Provider	§ 38.2-3407.13:2	The certificate and explanation of benefit must include notice for the enrollees, for services performed by a non-participating provider, informing the enrollee of his or her responsibility to apply the plan payment to the claim from such non-participating provider.	
Obstetrical Care	§ 38.2-3407.16	Obstetrical service benefits shall be no less favorable than for a physical illness generally.	

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Orally Administered Cancer Chemotherapy Drugs	§ 38.2-3407.18	Carriers shall include coverage for cancer chemotherapy drugs administered orally and intravenously or by injection and shall provide that the durational limits, deductibles, coinsurance factors and copayments for orally administered cancer chemotherapy drugs shall have consistently applied criteria within the same plan as those for cancer chemotherapy drugs that are administered intravenously or by injection.	
Handicapped Children	§ 38.2-3409	Dependent children who are incapable of self-sustaining employment by reason of intellectual disability or physical handicap and who are chiefly dependent on the insured for support and maintenance shall be covered beyond the specified age.	
Optional Coverage for Obstetrical Services	§ 38.2-3414	Policies shall provide coverage for obstetrical services as an option available to the group policyholder. Deductible and coinsurance factors shall be no less favorable than for physical illness.	
Postpartum Services	§ 38.2-3414.1	Plan providing benefits for obstetrical services must have coverage for postpartum services as provided in subsection B of this section.	
Exclusion or Reduction of Benefits	§ 38.2-3415	No plan shall reduce or exclude any benefits because benefits have been payable under any individual policy.	
Coverage for Victims of Rape/Incest	§ 38.2-3418	Policies or contracts which provide benefits as a result of an accident shall be construed to include benefits for pregnancy following an act of rape of an insured or subscriber.	
Mammograms	§ 38.2-3418.1	Policies shall provide coverage for low-dose screening mammograms at certain age intervals.	
Pap Smears	§ 38.2-3418.1:2	Each insurer shall provide coverage for annual pap smears, including coverage for annual testing performed by any FDA-approved gynecologic cytology screening technologies.	
Bones/Joints	§ 38.2-3418.2	Policies shall not exclude coverage or impose limits on treatment involving any bone or joint of the head, neck, face or jaw which are more restrictive than limits applicable to other bones or joints of the skeletal structure based on certain conditions.	
Hemophilia & Congenital Bleeding Disorders	§ 38.2-3418.3	Insurers shall provide coverage for treatment of hemophilia and congenital bleeding disorders. Benefits must include treatment of routine bleeding episodes, purchase of blood products and blood infusion equipment for home treatment.	
Reconstructive Breast Surgery	§ 38.2-3418.4	Insurers shall provide coverage for reconstructive breast surgery as outlined in this section coincident with or following a mastectomy, or following a mastectomy to reestablish symmetry between the two breasts.	
Early Intervention Services	§ 38.2-3418.5	Each policy shall provide coverage for medically necessary early intervention services which includes speech and language therapy, occupational therapy, physical therapy and assistive technology services and devices for certain dependents.	
Minimum Hospital Stay for Mastectomy/Lymph Node Dissection Patients	§ 38.2-3418.6	Coverage shall be provided for a minimum inpatient hospital stay of not less than 48 hours following a radical or modified radical mastectomy and not less than 24 hours of inpatient care following a total mastectomy or partial mastectomy with lymph node dissection for the treatment of breast cancer.	
PSA Testing	§ 38.2-3418.7	Coverage shall be provided for one PSA test in a 12-month period and digital rectal examinations for persons age 50 and over or age 40 if at high risk for prostate cancer.	

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Colorectal Cancer Screening	§ 38.2-3418.7:1	Each insurer shall provide coverage for colorectal cancer screening, specifically screening with an annual fecal occult blood test, flexible sigmoidoscopy or colonoscopy, or in appropriate circumstances, radiologic imaging.	
Minimum Hospital Stay for Hysterectomy	§ 38.2-3418.9	Each insurer shall provide coverage for a laparoscopy-assisted vaginal hysterectomy including a minimum stay in a hospital of not less than 23 hours and coverage for a vaginal hysterectomy including a minimum stay in a hospital of not less than 48 hours as provided in this section.	
Diabetes Coverage	§ 38.2-3418.10	Each insurer shall provide coverage for equipment, supplies and in-person outpatient self-management training and education, including medical nutrition therapy, for treatment of diabetes as specified in this section.	
Hospice Care	§ 38.2-3418.11	Each insurer shall provide coverage for hospice services including palliative and supportive physical, psychological, psychosocial and other health services to individuals with a terminal illness whose prognosis is death within six months and who elects to receive palliative care instead of curative care. Coverage for hospice services may be extended to include care when it cannot be demonstrated that the illness is terminal or for individuals with life expectancies of longer than six months.	
Dental Procedures – Hospital Stay/ Anesthesia	§ 38.2-3418.12	Each insurer shall provide coverage for medically necessary general anesthesia and hospitalization or facility charges of a facility licensed to provide outpatient surgical procedures for certain dental care.	
Treatment of Morbid Obesity	§ 38.2-3418.13	Policies shall provide coverage for treatment of morbid obesity as an option available to the group policyholder through gastric bypass surgery or other methods as stated in this section.	
Lymphedema	§ 38.2-3418.14	Policies or contracts shall provide coverage for lymphedema.	
Prosthetic Devices and Components	§ 38.2-3418.15	Offer and make available coverage for the health care services for medically necessary prosthetic devices, their repair, fitting, replacement, and components. A covered person's coinsurance for in-network prosthetic devices must not be in excess of 30%.	
Telemedicine Services	§ 38.2-3418.16	Coverage shall be provided for health care services through telemedicine services.	
Coverage for Autism Spectrum Disorder	§ 38.2-3418.17	Coverage and the treatment for the diagnosis of autism spectrum disorder from age two through age ten shall be provided, subject to annual maximum benefit limitations set forth in subsection K of this section of the Code. See Code regarding coverage for services beyond the required age.	
Waiting Period	§ 38.2-3452	Waiting period for group enrollee shall be no longer than 90 days before being eligible for coverage.	
Pharmacy Freedom Choice	§ 38.2-4209.1	If a plan has outpatient prescription drug benefits, the plan must allow for freedom of choice of pharmacies, if non-participating pharmacies agree in writing to accept reimbursement, including copayment, at the same rates as participating pharmacies.	
Dependent Coverage	PHSA §2714 (45 CFR §147.120) § 38.2-3409 § 38.2-3411 § 38.2-3411.2 § 38.2-3438	Dependent children who are incapable of self-sustaining employment by reason of intellectual disability or physical handicap shall be covered beyond the specified age. Plan shall provide newborn coverage from the moment of birth. Coverage must be same as for the insured including congenital defects and birth abnormalities. Must notify Insurer within 31 days of birth for coverage to continue.	

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	§ 38.2-3439	<p>Any insurance benefits applicable for children under the policy shall be payable with respect to adopted children or children placed in foster care.</p> <p>If a policy offers dependent coverage, it must include dependent coverage to age 26 without restriction to financial dependency, residency, marital, student or employment status, or eligibility for other coverage.</p>	
Annual and Lifetime Limits	PHSA §2711 (45 CFR §147.126) § 38.2-3440	This limits the ability for companies to impose annual and lifetime dollar limits on essential health benefits in and out-of-network.	
Rescissions	PHSA §2712 (45 CFR §147.128) § 38.2-3441	<p>Rescissions are prohibited except for an act, practice, or omission that constitutes fraud or the individual makes an intentional misrepresentation of material fact in the application.</p> <p>The insurer must provide at least 30 days advance written or electronic notice to each participant who would be affected before coverage may be rescinded.</p>	
Preventive Services	PHSA §2713 (45 CFR §147.130) § 38.2-3442	This requires non-grandfathered plans to cover in network preventive health and wellness services without out-of-pocket cost-sharing (co-insurance, co-payment or deductible). Carriers must provide a weblink in the policy form allowing members to determine the services that will be covered with no cost-sharing.	
Access to OB/GYN	PHSA §2719A (45 CFR §147.138) § 38.2-3443	<p>The plan must not require prior authorization or referral requirements for obstetrical or gynecological care if care is provided by in-network providers specializing in obstetrics or gynecology.</p> <p>A health carrier shall provide notice to a covered person of the terms and conditions of the plan related to the designation of a participating healthcare professional.</p>	
No Pre-existing Condition Exclusions	PHSA §2704 and §1255 (45 CFR §147.108) § 38.2-3444	Issuers may not impose pre-existing condition exclusions.	
Emergency Services	PHSA §2719A (45 CFR §147.138) § 38.2-3445	<p>Plans must cover in and out-of-area emergency services, including ambulance services available 24 hours a day, 7 days a week.</p> <p>Plans must cover emergency services. Such coverage must be without requirements for prior authorization or requirement that service be provided by a participating provider.</p> <p>Cost sharing (copay and coinsurance amounts) must not differ from the in-network level. Deductibles and out-of-pocket maximums that apply generally to out-of-network benefits may be imposed on out-of-network emergency services.</p>	

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		Plans must pay for out of network emergency services the greatest of: (1) the median in-network rate; (2) the usual and customary rate (or similar rate determined using the issuer's general formula for determining payments for out-of-network services); or (3) the Medicare rate.	
Emergency Services Definitions	PHSA §2719A (45 CFR §147.138) § 38.2-3438	<p>“Emergency medical condition means a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in (i) serious jeopardy to the mental or physical health of the individual, (ii) danger of serious impairment to bodily functions, (iii) serious dysfunction of any bodily organ or part, or (iv) in the case of a pregnant woman, serious jeopardy to the health of the fetus.”</p> <p>“Emergency services means with respect to an emergency medical condition, a medical screening examination that is within the capability of the emergency department, including ancillary services routinely available to the emergency department to evaluate the condition; and within the capabilities of the staff/facilities available at the hospital, examination/ treatment required to stabilize the patient.”</p> <p>“Stabilize means to provide treatment that assures that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility, or with respect to a pregnant woman, that the woman has delivered, including the placenta.”</p>	
Primary Care Providers	PHSA §2713 (45 CFR §147.130) § 38.2-3443	<p>Network plans requiring or providing for a primary care health professional to be designated must:</p> <ol style="list-style-type: none"> 1. allow each enrollee to designate any participating primary healthcare professional who is available to accept such individual. 2. a participating healthcare professional specializing in pediatrics and available to accept children may be designated as primary healthcare provider. 3. Notice of these is required when carrier provides primary subscriber with a policy, certificate, or contract of health insurance. 	
Provider Nondiscrimination	PHSA §2706 § 38.2-4221	Providers operating within their scope of practice, license or certification cannot be discriminated against.	
Clinical Trials	§ 38.2-3418.8 § 38.2-3453	Each insurer shall provide coverage for participation in an approved clinical trial for treatment studies on cancer or other life-threatening disease or condition and cover routine patient costs for items and services in connection with participation in the trial.	
“Michelle’s Law”	PHSA §2728 (45 CFR §147.145) § 38.2-3525 E	<p>Coverage for dependent student on <u>medically necessary leave of absence</u> (“Michelle’s Law”)</p> <p><input type="checkbox"/> Issuer cannot terminate coverage due to a medically necessary leave of absence before:</p>	

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		<ul style="list-style-type: none"> • The date that is 1 year after the first day of the leave; or • The date on which coverage would otherwise terminate under the terms of the coverage. <p><input type="checkbox"/> Change in benefits prohibited – child on medically necessary leave of absence is entitled to the same benefits as if the child continued to be a covered student who was not on a medically necessary leave of absence; however, if there is a change in the manner in which the beneficiary/parent is covered and continues to cover the dependent, the changed coverage will apply for the remainder of the period of the medically necessary leave of absence.</p> <p><input type="checkbox"/> Eligibility for protections: a dependent child under the terms of the coverage of the beneficiary, enrolled in the coverage on the basis of being a student immediately before the first day of the medically necessary leave of absence involved.</p> <p><input type="checkbox"/> <u>Medically necessary leave of absence</u> means: a leave of absence or change of enrollment of a dependent child from a postsecondary education institution that:</p> <ol style="list-style-type: none"> 1. Commences while the child is suffering from a serious illness or injury; 2. Is medically necessary; and 3. Causes the child to lose student status for purposes of coverage under the terms of coverage. <p><input type="checkbox"/> Issuer must include with any notice regarding a requirement for certification of student status for coverage, a description of the terms for continued coverage during medically necessary leaves of absence.</p>	
Cost Sharing Limits	42 USC §18022 26 USC §223(c)(2) (A)(ii) 2017 Notice of Benefit and Payment Parameters § 38.2-3451	<p><u>Cost-sharing</u> in-network limited to maximum out-of-pocket for high deductible health plans in 2014 (adjusted by IRS), increased by this amount multiplied by the premium adjustment percentage set by HHS (\$7,150 individual/\$14,300 family for 2017).</p> <p><u>Cost-sharing</u> includes deductibles, coinsurance, copayments, or similar charges; and any other expenditure required of an insured individual which is a <u>qualified medical expense</u> for EHB covered under the plan. Non EHB cost-sharing may contribute to cost-sharing limit.</p> <p><u>Qualified medical expense</u> means an expense paid by the insured person for medical care for her/himself, covered spouse, and covered dependent(s) that are not compensated for by insurance or otherwise.</p>	

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		Plans that use separate service providers may have non-integrated maximum out-of-pocket limits as long as the total amount for the plan does not exceed the 2017 cost-sharing limit. Mental health/substance abuse benefits must not have separate limits than other services in general. The contract must clearly describe any and all out-of-pocket maximums and deductible limits. For family limits on cost sharing, the contract must not show limits or maximums for an individual unless that limit or maximum may apply.	
Guaranteed Renewability	PHSA §2702 (45 CFR §146.152 and 147.106) (See also § 38.2-3432.1)	Coverage is guaranteed renewable at the option of the insured except when there is no longer an individual that lives, works, or resides in the service area. May only non-renew or cancel coverage for nonpayment of premiums, fraud, violation of material participation or contribution rules, carrier terminates the type of health insurance coverage (product) (90 days' notice), market exit (180 days' notice), movement outside of service area (90 days' notice), or coverage is uniformly terminated when association membership ceases. Medicare eligibility or entitlement is not a basis for non-renewal or cancellation. NOTE: Student health plans are not subject to Guaranteed Renewability and Guaranteed Availability.	
Notice upon Termination	§ 38.2-3542 A	Certain employers shall give written notice to participating employees in the event of termination or upon the receipt of notice of termination of any such policy not later than 15 days after the termination of a self-insured plan or receipt of the notice of termination.	
Termination Notice Employer	§ 38.2-3542 C	Notice must be given to employer at least 15 days prior to terminating contract due to non-payment of premiums.	
Continuation	§ 38.2-3541	Each policy shall contain a provision that sets forth a provision for continuation of coverage.	
Explanation of Internal Appeals Process	45 CFR §147.136 29 CFR §2560.503-1 § 38.2-305 § 38.2-3570 § 38.2-5803 14 VAC 5-216-30	Specific requirements to be included in or attached to policy: 1. The procedure must identify timeframes to submit internal appeals on a standard, concurrent or urgent care basis, and timeframes for the issuer to respond to these appeals in accordance with federal and state law; 2. No fee can be charged for appeals process; 3. The procedures must not unduly inhibit initiation or processing of claims; 4. Plans must include contact information for enrollee to submit an appeal, including name, address, and phone number; 5. Issuer must allow an authorized representative of the claimant to act on behalf of the claimant in pursuing a benefit claim or appeal of an adverse benefit determination. In an urgent care appeal, the issuer must recognize a health care professional with knowledge of the person's medical condition as an authorized representative. 6. Plans must include required contact information for the Bureau; and 7. (For MCHIPs) Plans must include the required statement in VA Code § 38.2-5803 A 5 to include contact information for the Office of the Managed Care Ombudsman, indicating	

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Explanation of Right to External Review	45 CFR §147.136 29 CFR §2560.503-1 § 38.2-3570	<p>the mailing address, email address and local and toll-free phone number.</p> <p>Specific requirements to be included in or attached to policy:</p> <ol style="list-style-type: none"> 1. An explanation of the right to file a request for external review of adverse determinations or final adverse determinations with the Bureau, including an explanation of those determinations eligible for external review: determinations based on medical necessity, appropriateness, health care setting, level of care, or effectiveness, or a determination that a service is experimental/investigational; 2. Notification that the enrollee will be required to authorize the release of medical records required for the external review. 	
Claims Procedures	45 CFR §147.136 29 CFR §2560.503-1	<p>The following rules relate to requirements for initial adverse benefit determinations. These processes fall under the jurisdiction of the Virginia Department of Health (VDH), Office of Licensure and Certification, and are included in this checklist for informational purposes only. <u>The Bureau does not speak for VDH, and any VDH requirements or guidelines take precedence over this information.</u></p> <p>General requirements for Claims Procedures:</p> <ol style="list-style-type: none"> 1. required to include a description of: <ol style="list-style-type: none"> a. claims procedures, b. procedures for obtaining prior approval, c. preauthorization procedures, d. utilization review procedures, and e. applicable time frames 2. The claims procedure cannot unduly inhibit the initiation or processing of claims. <p>A <u>claim for benefits</u> is a request for benefits made by a claimant in accordance with an issuer's reasonable procedure for filing benefit claims, including pre-service and post-service claims.</p> <p>Time and process for urgent care (pre-service, post-service):</p> <ol style="list-style-type: none"> 1. Determination for urgent care must be made within 72 hours. 2. Notice of the determination within 72 hours of receipt of the claim. 3. Notice of urgent care decisions must include a description of the expedited review process applicable to such claim. 4. No extension of the determination time-frame is permitted. 5. If the claimant fails to provide sufficient information, issuer must notify the claimant within 24 hours and must include specific information necessary to complete the claim. 6. The claimant must have at least 48 hours to provide the specified information. 7. A determination must be made within 48 hours of receiving specified information or 	

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		<p>expiration of time afforded to the claimant to provide the specified information (whichever is earlier).</p> <p>Time and process for concurrent urgent care (at the request of the claimant):</p> <ol style="list-style-type: none"> 1. Claim for concurrent urgent care: Refers to a claimant requesting to extend the course of treatment beyond time/number of treatments. 2. Claim for concurrent urgent care: if a claimant requests to extend the course of treatment beyond time/number of treatments. 3. Claim must be made at least 24 hours prior to the expiration of the prescribed period of time/number of treatments. 4. Determination must be made within 24 hours. 5. Notification is required within 24 hours of the claimant's request. <p>Time and process for pre-service claim:</p> <ol style="list-style-type: none"> 1. Determination and notification for a pre-service claim must be made within 15 days of the request of the claim. 2. Determination extension up to 15 days allowed if necessary due to matters beyond the control of the issuer. 3. Notice required of the extension prior to the expiration of the initial 15-day period. 4. The issuer must identify for the claimant the circumstances requiring the extension and date by which the issuer expects to render a decision. 5. If the claimant fails to provide sufficient information, the issuer must notify the claimant and specifically describe the required information needed to render a decision. 6. Claimant has 45 days from receipt of notice of insufficient information to provide specified information. <p>Time and process for on-going services/treatment (concurrent care decisions):</p> <ol style="list-style-type: none"> 1. Reduction/termination of benefits of ongoing courses of treatment (concurrent care) before the end of the time/treatments is considered an adverse benefit determination. 2. Determination and notice of determination for concurrent care must be made sufficiently in advance of the reduction/termination of benefits to allow the claimant to appeal and obtain a determination on the review of the adverse benefit determination BEFORE reduction/termination. <p>Time and process for post-service claim:</p> <ol style="list-style-type: none"> 1. Determination for post-service claim must be made within 30 days of receipt of claim. 2. Notice of the determination must be made within 30 days of receipt of the claim. 3. Determination extension up to 15 days is allowed if necessary due to matters beyond the control of the issuer. Notice of the extension must be provided to the claimant prior to 	

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	§ 38.2-3559 § 38.2-3562 § 38.2-3563 § 38.2-5803 14 VAC 5-216-30 14 VAC 5-216-40 14 VAC 5-216-70 Administrative Letter 2011-05	<p>expiration of the initial 30-day period. The issuer must indicate the circumstances requiring the extension and date by which the issuer expects to render a decision.</p> <p>4. If claimant fails to provide necessary information, the issuer must provide notice, which includes the specific information necessary to render a decision. The claimant has at least 45 days from the receipt of notice to provide the specified information.</p> <p>Standards for all required notices: (This information is not required to be in the policy, but nothing in the policy may conflict.)</p> <ol style="list-style-type: none"> 1. Issuer must provide the claimant with written or electronic notification of any adverse benefit determination for pre-service, post-service, and concurrent treatment claims. 2. All notices of adverse benefit determination (including final internal adverse benefit determinations) must be provided in a culturally and linguistically appropriate manner and must include: <ol style="list-style-type: none"> a. In the English version, a statement prominently displayed in any applicable non-English language indicating how to access the issuer's language services; b. Information sufficient to identify the claim involved including date of service, health care provider, claim amount, and, upon request, diagnosis/treatment codes and their meanings; c. Specific reason for the adverse benefit determination, including the denial code and its corresponding meaning and a description of the issuer's standard that was used in denying the claim; d. Diagnosis/treatment codes and meanings must be provided as soon as practicable. Requests for this information cannot be considered a request for an internal appeal or external review; e. Statement indicating that the claimant has access to all documents related to claim; f. applicable expedited review process; g. a description of available internal appeals and external review processes (to include applicable timeframes for enrollee submission and issuer response – standard and expedited or urgent care); h. contact information to submit appeal or complaint – name, address, telephone number; i. claimant's right to bring civil action under §502(a) of ERISA if applicable; j. availability of and contact information for health insurance consumer assistance or, if MCHIP, ombudsman; and k. claimant's right to request an external review if he or she has not received a final benefit determination within the required timeframes, unless the claimant agreed to the delay. 3. An adverse determination must describe: <ol style="list-style-type: none"> a. all of the information in an adverse benefit determination; 	

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		b. required language of VA Code § 38.2-3559; c. process in which an external review may be requested if issuer does not meet review timeframes; d. website and phone number to assist claimant in requesting an external review in the above circumstance; and e. notice that an expedited review: (i) is available if medically needed or for experimental/investigational treatments; and (ii) can be requested at the same time as an expedited internal appeal.	
Internal Appeals	PHSA §2719 (45 CFR §147.136) 14 VAC 5-216-40	<p><i>Procedures described in the policy should reflect these timeframes and not contradict this process. Internal appeals of adverse benefit determinations - processes, rights and required notices:</i></p> <ol style="list-style-type: none"> 1. Enrollees have a right to one internal appeal of an adverse benefit determination. 2. Enrollees may review the claim file and present evidence and testimony as part of the internal appeals process. 3. Enrollees have at least 180 days following receipt of a notification of an adverse benefit determination within which to appeal. 4. Enrollees must have access to an expedited review process. Requests for expedited review must be allowed to be submitted orally or in writing. 5. A clinical peer reviewer must review appeals involving medical judgment. 6. Appeal reviewer must not be involved with previous claim. 7. Issuer must identify person rendering any expert advice. <p><i>Procedures described in the policy should reflect these timeframes and not contradict this process. In addition to adverse benefit determination and adverse determination requirements, a final adverse determination notification must include:</i></p> <ol style="list-style-type: none"> 1. A statement that the communication represents a final adverse determination; 2. Forms necessary to request an external review; and 3. Notice of expedited external review available if the decision involves emergency care, and patient has not been discharged from facility. <p><u>Pre-service claim:</u> Determination and notification must be made within 30 days after receipt of the claimant's request.</p> <p><u>Post-service claim:</u> Determination and notification must be made within 60 days after receipt of the claimant's request.</p>	

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		<p>9. For standard reviews (not urgent), the IRO must inform the issuer and the claimant in writing of its decision within 45 days from the Independent Review Entity's receipt of the request for review.</p> <p>Urgent care:</p> <ol style="list-style-type: none"> 1. The process must provide for expedited external review of urgent care claims. 2. The IRO must inform the issuer, the claimant, and the Bureau of an urgent care decision within 72 hours from receipt of an eligible request for review. <p>If the IRO's decision was given orally, the IRO must provide written notice of the decision within 48 hours of the oral notification.</p>	
Enrollment Periods for Qualified Individuals	45 CFR §146.117 § 38.2-3432.3 § 38.2-3448	<p>Provide and disclose enrollment periods for qualified individuals:</p> <p>30 days from the date of the following: Employee or dependent loss of coverage; termination of employer contributions; exhaustion of COBRA continuation coverage; marriage, birth, adoption or placement for adoption.</p>	