Form Filing Review Checklist
HEALTH MAINTENANCE ORGANIZATIONS (HMOs)
(LARGE GROUP)

Print Reset Form

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 Forms and Rates Section of the Life and Health Division will review submissions based on the requirements noted in this checklist. Please contact this Section at (804) 371-9532 if you have questions or need additional information about these requirements.

Company Name:	
Product Name:	SERFF Tracking Number:

REVIEW REQUIREMENTS	FEDERAL AND/OR VIRGINIA CITATION	COMMENTS	PAGE NO.
General Filing Requirements			
	14VAC5-100-40 1	Each form 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.	
	14VAC5-100-40 3	Certification of Compliance signed by the General Counsel or officer of company or attorney or actuary representing the company is required.	
	14VAC5-100-40 5	Description of market for which the form is intended.	
Form Number	14VAC5-100-50 1 § 38.2-3500 A 5	Form number must appear in lower left-hand corner of the **first page** of each form.	
Company Name and Address	14VAC5-100-50 2	Full and proper corporate name (including "Inc." or "The") must prominently appear on cover sheet of all policies and other forms. Home office address of insurer must prominently appear on each policy.	
Final Form	14VAC5-100-50 3	Form must be submitted in the final form in which it will be issued and completed in "John Doe" fashion to indicate its intended use.	
Application	14VAC5-100-50 4	Any form, which is 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 application was previously approved, provide SERFF tracking number or copy with approval date).	
Type Size	14VAC5-100-50 5	All forms must be printed with type size of at least 8-point type.	
Additional SERFF Filing Requirements	***14VAC5-100-40 and SERFF Filing Instructions***	***Additional SERFF filing requirements must be met as specified below for life and health forms and rate filings.***	
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			
		Regarding the plan submitted with this filing, is the provider network consistent with the information previously filed and approved under Section 38.2-5802? ☐ Yes ☐ No If no, this filing must include the following: 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 as to 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. 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. 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	A 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. **Provide most recent approval date of Complaints and Appeals process from the Bureau of Insurance and Virginia Department of Health. Please attach copies of approvals under Supporting Documentation. Is the language in the submitted forms identical in substance to the approved language?**	
Bureau of Insurance & Department of Health	§ 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."	

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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 that 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 Policy Provisions			
Contents of Policy	§ 38.2-305 A	Each policy/contract shall specify the: (1) The names of parties to the contract, (2) The subject of the insurance, (3) The risk insured against, (4) The time the insurance takes effect and, the period during which the insurance is to continue, (5) A statement of premium, and (6) The conditions pertaining to the insurance.	
Important Notice	§ 38.2-305 B	Each new or renewal policy/contract/certificate/evidence of coverage shall be accompanied by an important notice as stated in the statute.	
Fraud Notice	§ 38.2-316 D 1	Title 38.2 of the Code of Virginia does not define "Insurance Fraud." Any fraud notice that includes the term "insurance fraud" is not in compliance with this section of the Code. In Virginia, a fraud notice relating to life insurance, annuities, accident and sickness, health maintenance organizations, health services plans, credit accident and sickness and credit life insurance should not include references to imprisonment or fines. Variations in a notice warning of consequences of making fraudulent statements will be considered.	
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.	

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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 Insurance Prohibited	§ 38.2-3405 B 14VAC5-211 80 a	No plan shall require a 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	§ 38.2-3405 D	Except for specified circumstances, issuers shall not exclude coverage for any medical condition whenever benefits payable under workers' compensation are excluded from coverage.	
Calculation of Cost-Sharing Provisions	§ 38.2-3407.3	Coinsurance the member is required to pay must be based upon the amount actually paid or payable to the provider. Statements in the EOC or Schedules that refunds, rebates and post-payment adjustments will not be considered in the calculation of coinsurance are prohibited.	
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.	
Hormonal Contraceptives	§ 38.2-3407.5:2	A plan covering hormonal contraceptives shall cover up to a 12-month supply when dispensed or furnished at one time.	
Denial of Benefits for Certain Prescription Drugs Prohibited	§ 38.2-3407.6:1	Each policy must contain language indicating benefits will not be denied for any USFDA approved drug to treat cancer pain because the dosage is in excess of the recommended dosage, if prescribed for a patient with cancer pain.	
Ambulance Services	§ 38.2-3407.9	Policies covering ambulance services must provide that the ambulance provider will receive reimbursement from the health carrier when there is an assignment of benefits. 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 HMO 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.	
Partial Supply of Prescription Drugs	§ 38.2-3407.9:04	Prescriptions dispensed by a network pharmacy for a partial supply of a covered prescription drug, in order to synchronize the enrollee's medications, must be covered at a prorated cost-sharing rate.	
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 2nd 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.	
Preauthorization Personnel	§ 38.2-3407.10 L	Where preauthorization is required for treatment, HMO's must have personnel available to provide such authorization when required.	
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 Referral for Cancer Patients	§ 38.2-3407.11:2	The plan must have 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.	

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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 but having been cancer free for 5 years or more.	
Claims Paid to Insureds for Services from Nonpar. Providers	§ 38.2-3407.13:2	When an HMO follows a policy of sending payment to the enrollee, 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.	
Opt. Point of Service Benefit	§ 38.2-3407.12	POS benefit must be offered in conjunction with every healthcare plan offered by an HMO in Virginia.	
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	When an HMO follows a policy of sending payment to enrollee, the certificate and explanation of benefit must include notice for 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.	
Proton Radiation Therapy Decisions	§ 38.2-3407.14:1 B	Each policy or contract that provides coverage for cancer therapy shall not hold proton radiation therapy to a higher standard of clinical evidence than for decisions regarding coverage of other types of radiation therapy treatment.	
Obstetrical Care	§ 38.2-3407.16	Obstetrical service benefits shall be no less favorable than for a physical illness generally.	
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.	
Calculation of Cost Sharing	§ 38.2-3407.20	Cost-share amounts paid by an enrollee or on behalf of an enrollee shall count toward any out-of-pocket maximum or cost-sharing requirements, to the extent allowed by federal law and regulation.	
Newborn Children	§ 38.2-3411	Coverage on an expense incurred basis that provides coverage for a family member of the insured shall, as to the family members' coverage, also provide that the accident and sickness insurance benefits applicable for children shall be payable with respect to a newly born child of the insured from the moment of birth.	
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.	

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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 an 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 and Congenital Bleeding Disorders	§ 38.2-3418.3	Insurers shall provide coverage for 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 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.	
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 an 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 or 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.	

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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 6 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	Covers interactive telemedicine, such as audio, video, orotherelectronic technology or media (other than audio-only telephone, e-mail, fax, or on-line questionnaire) for diagnosis, consultation, or treatment of covered services. Covers remote patient monitoring as described in the code.	
Coverage for Autism Spectrum Disorder	§ 38.2-3418.17	Coverage and the treatment for the diagnosis of autism spectrum disorder from age two through 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. Any policy issued or reissued on or after 1/1/2020 shall provide this benefit to covered individuals of any age.	
Waiting Periods	§ 38.2-3452	Waiting periods for group enrollees shall be no longer than 90 days before being eligible for coverage.	
Notice upon Termination	§ 38.2-3542 A	Certain employers shall give written notice to participating employees in the event of termination or upon 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	
EOC Must be Provided	§ 38.2-4306 A 1	Each subscriber shall be entitled to an Evidence of Coverage (EOC).	
Misleading Statements	§ 38.2-4306 A 3	No EOC shall contain statements that are unjust, unfair, untrue, inequitable, misleading, deceptive or misrepresentative.	

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Complete Statement of Benefits	§ 38.2-4306 A 4 (a)	An EOC shall contain a complete summary of health care services and other benefits the enrollee is entitled.	
State Limits and Copayments	§ 38.2-4306 A 4 (b)	An EOC shall contain any limits on services, including deductibles and copayments.	
Describes Service Delivery	§ 38.2-4306 A 4 (c)	An EOC must contain where and in what manner services may be obtained.	
Contributory/Non-Contributory	§ 38.2-4306 A 4 (d)	An EOC must state if plan is contributory or non-contributory if group plan, and premium amount for individual contracts.	
Complaint Procedures	§ 38.2-4306 A 4 (e)	An EOC must contain enrollee complaint procedures.	
Provider List/Service Area	§ 38.2-4306 A 4 (f)	Provider list and service area description must be presented with an EOC, if information is not given to the subscriber at enrollment. Provider lists and service area description must be available on request or provided at least annually.	
24 Hour On Call	§ 38.2-4312.3	Plan must provide access to care and access by telephone to a physician or licensed medical professional who can direct or refer the member where there is an immediate, urgent need or medical emergency.	
Dependent Coverage	PHSA § 2714 (45 CFR § 147.120) § 38.2-3411 § 38.2-3411.2 § 38.2-3438 § 38.2-3439	Any insurance benefits applicable for children under the policy shall be payable with respect to adopted children or children placed in foster care. 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.	
Continuation of Coverage	14VAC5-211-70 A	Each policy shall contain a provision that provides for continuation of coverage.	
Cost Sharing	14VAC5-211-90 A	Copayment must be shown in EOC as a specified dollar or as a coinsurance, not both.	
Cost Sharing Notification	14VAC5-211-90 B	Plan shall keep cost sharing records, shall notify enrollee no later than 30 days after out-of-pocket maximum or cost sharing is reached, shall not charge any further cost sharing that year, and shall promptly refund any excess cost sharing paid. EOC must clearly state procedures.	
Extension of Benefits	14VAC5-211-130	Plan must offer extension of benefits, upon discontinuance of contract, to members who are totally disabled at discontinuance. Upon payment of premium, coverage shall remain in force for not less than 180 days, or until such time as a succeeding carrier elects to provide coverage without limitation as to the disabling condition, or until member is no longer totally disabled.	
Name, Address and Telephone Number	14VAC5-211-210 B 1	An EOC must contain name, address and telephone number of HMO.	
Effective Date and Term of Coverage	14VAC5-211-210 B 5	An EOC must contain effective date and term of coverage.	

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Arbitration	14VAC5-211-210 B 7	A description of the HMO's method of resolving enrollee complaints, including a description of any arbitration procedure if complaints may be resolved through a specified arbitration agreement.	
COB Provisions	14VAC5-211-210 B 11	An EOC must contain any coordination of benefits provisions.	
Assignment Restrictions	14VAC5-211-210 B 12	An EOC must contain any assignment of benefit restrictions in contract.	
Claim Filing/Proof of Loss	14VAC5-211-210 B 13	An EOC must contain the plans' claim filing procedures and proof of loss requirements.	
Eligibility Requirements	14VAC5-211-210 B 14	Conditions under which dependents may be added.	
Entire Contract	14VAC5-211-210 B 15	An EOC shall contain a provision that the contract or evidence of coverage and any amendments to it constitutes the entire contractual agreement between the parties involved and that no portion of the charter, bylaws, or other document of the health maintenance organization shall constitute part of the contract unless it is set forth in full in the contract.	
Grace Period	14VAC5-211-210 B 16	An EOC shall contain a provision that the policyholder is entitled to a grace period of not less than 31 days for the payment of any premium due, except for the first premium. During the grace period, the coverage shall continue in force.	
Reasons for Termination	14VAC5-211-230 A	Plan may not terminate a member, except for listed reasons: Failure to pay premiums, fraud or intentional misrepresentation of material fact, discontinuance of group, or failure to meet eligibility requirements.	
Termination Rules	14VAC5-211-230 B	An EOC must contain terms and conditions under which coverage may be terminated. An HMO must provide a 31-day notice of termination, except for non-payment of premiums and change in eligibility status.	
Additional Provisions			
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 (445 CFR § 147.128) § 38.2-3441	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. 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.	
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.	

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Access to OB/GYN	PHSA § 2719A (45 CFR § 147.138) § 38.2-3443	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. 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.	
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 14VAC5-211-160 A 5	Plans must cover in and out-of-area emergency services, including ambulance services available 24 hours a day, 7 days a week. Plans must cover emergency services. Such coverage must be without requirements for prior authorization or any requirement that service be provided by a participating provider. 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 as out-of-network emergency services. Plans that permit balance billing for out-of-network emergency services must indicate in the policy or contract that plan payment for out-of-network emergency services is based on the greatest of: (1) The amount negotiated with in-network providers for the emergency service, or if more than one amount is negotiated, 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 for the emergency service.	
Emergency Services Definitions	PHSA § 2719A (45 CFR § 147.138) § 38.2-3438 § 38.2-4300	"Emergency medical condition means a medical condition manifesting itself by acute symptoms of sufficient severely, including severe pain, so that a prudent layperson reasonably expect the absence of immediate medical attention to result in a condition that places the physical or mental health of the individual in serious jeopardy, would result in serious impairment to bodily functions, or serious dysfunction of any bodily organ with respect to a pregnant woman, serious jeopardy to the health of the fetus."	

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		"Emergency services means those health care services that are rendered by affiliated or nonaffiliated providers after the sudden onset of a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine to result in: (i) Serious jeopardy to the mental or physical health of the individual, (ii) Danger of serious impairment of the individual's bodily functions, (iii) Serious dysfunction of any of the individual's bodily organs, or (iv) In the case of a pregnant woman, serious jeopardy to the health of the fetus. "Emergency services provided within the plan's service area shall include covered health care services from nonaffiliated providers only when delay in receiving care from a provider affiliated with the health maintenance organization could reasonably be expected to cause the enrollee's condition to worsen if left unattended." "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."	
Primary Care Providers	PHSA § 2713 (45 CFR § 147.130) § 38.2-3443 14VAC5-211-140	Network plans requiring or providing for a primary care health professional to be designated must: 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 § 38.2-4312	Providers operating within their scope of practice, license or certification cannot be discriminated against.	
Nondiscriminatory Benefit Design	14VAC5-211-240 A	Plan may not unfairly discriminate against any enrollee on the basis of the age, sex, health status, race, color, creed, national origin, ancestry, marital status, lawful occupation of the enrollee, or because of the frequency of utilization of services by the enrollee.	
Clinical Trials	§ 38.2-3418.8	Each insurer shall provide coverage for participation in an approved clinical trial for treatment studies on cancer or other life-threatening disease for condition and cover routine patient costs for items and services in connection with participation in the trial.	

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Cost Sharing Limits	42 USC § 18022 26 USC § 223(c)(2)(A)(ii) 2020 Proposed Notice of Benefit and Payment Parameters § 38.2-3451	Cost-sharing 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 ($8,150 individual/$16,300 family for 2020). Cost-sharing includes deductibles, coinsurance, copayments, or similar charges; and any other expenditure required of an insured individual which is a qualified medical expense for EHBs covered under the plan. Non EHB cost-sharing may contribute to cost-sharing limit. Cost-sharing does not include balance billing amounts for non-network providers. Qualified medical expense means an expense paid by the insured person for medical care for her/himself, covered spouse, and covered dependent(s) that re not compensated for by insurance or otherwise. 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 2020 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.	
"Michelle's Law"	PHSA § 2728 (45 CFR § 147.145) § 38.2-3525 E	**Coverage for dependent student on medically necessary leave of absence ("Michelle's Law")** ☐ Issuer cannot terminate coverage due to a medically necessary leave of absence before: ● 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. ☐ 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.	

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		☐ 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. ☐ Medically necessary leave of absence means: a leave of absence or change of enrollment of a dependent child from a postsecondary education institution that: 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 purpose of coverage under the terms of coverage. ☐ 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 leave of absence.	
Copayment Amount	14VAC5-211-90 A	Copayment must be shown in EOC as a specified dollar or as a coinsurance.	
Copayment Notification	14VAC5-211-90 B	Plan shall keep copayment records, shall notify enrollee no later than 30 days after copayment maximum is reached, shall not charge any further copayments that year, and shall promptly refund any excess copayments paid. An EOC must clearly state procedures.	
Guaranteed Renewability	PHSA § 2702 (45 CFR § 147.106, and 148.122) (See also § 38.2-3514.2 and 3430.7) 45 CFR 146.152 and 147.106 § 38.2-3432.1 *(depends on group or individual)*	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, carrier terminates the type of health insurance coverage (product) (90 days' notice), market exit (180 days' notice), movement outside of service area, or coverage is uniformly terminated when association membership ceases. Medicare eligibility or entitlement is not a basis for non-renewal or cancellation when renewing into the same policy. **NOTE: Student health plans are not subject to Guaranteed Renewability and Guaranteed Availability.**	

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Explanation of Internal Appeals Process	45 CFR § 147.136 29 CFR § 2560.503-1 § 38.2-305 § 38.2-3570 § 38.2-5803 14VAC5-216-30	**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 of the Office of Managed Care Ombudsman, indicating the mailing address, email address and local and toll-free phone number.	
Explanation of Right to External Review	45 CFR § 147.136 29 CFR § 2560.503-1 § 38.2-3570	**Specific requirements to be included in or attached to policy:** 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	**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>** **General requirements for Claims Procedures:** 1. Required to include a description of: a. Claims procedures, b. Procedures for obtaining prior approval,	

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		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. A claim for benefits 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. **Time and process for urgent care (pre-service, post-service):** 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 expiration of time afforded to the claimant to provide the specified information (whichever is earlier). **Time and process for concurrent urgent care (at the request of the claimant):** 1. Claim for concurrent urgent care: Refers to a claimant 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.	

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		Time and process for pre-service claim: 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. **Time and process for on-going services/treatment (concurrent care decisions):** 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. **Time and process for post-service claim:** 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 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. 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.	

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	§ 38.2-3559 § 38.2-3562 § 38.2-3563 § 38.2-5803 14VAC5-216-30 14VAC5-216-40 14VAC5-215-70 Administrative Letter 2011-05	**Standards for all required notices: (This information is not required to be in the policy, but nothing in the policy may conflict.)** 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: 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: 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 the adverse determination involves cancer, 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) 14VAC5-216-40 § 38.2-3559	***Procedures described in the policy should reflect these timeframes and not contradict this process.*** **Internal appeals of adverse benefit determinations – processes, right and required notices:** 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 judgement. 6. Appeal reviewer must not be involved with previous claim. 7. Issuer must identify person rendering any expert advice. ***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:** 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. <u>Pre-service claim</u>: Determination and notification must be made within 30 days after receipt of the claimant's request.	

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	14VAC5-216-50	Post-service claim: Determination and notification must be made within 60 days after receipt of the claimant's request. Urgent claim: 1. Determination and notification musts be made within 72 hours after receipt of the claimant's request. a. If claimant fails to provide sufficient information to determine covered/payable benefits for an urgent claim, the issuer must: i. Notify the claimant within 24 hours of the information necessary to complete the claim. ii. Give the claimant at least 48 hours to provide the specified information. iii. Provide notice of the determination within 48 hours of the earlier of receiving the specified information and the end of the time period provided to return the specified information. Notice must be provided in the most expeditious method available. The issuer must provide the claimant with written or electronic notice of the determination in a culturally and linguistically appropriate manner. An adverse benefit determination means a denial, reductions, or termination of, or failure to provide or make payment for a benefit, including denial, reductions, or termination of, or failure to provide or make payment based on a determination of beneficiary's eligibility to participate in a plan, and including denial, reductions, or termination of, or failure to provide or make payment for a benefit resulting from the application of utilization review, as well as failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate. A rescission of coverage or any decision to deny individual coverage in an initial eligibility determination must be treated as an adverse benefit determination.	
	§ 38.2-3560 14VAC5-216-20	An adverse determination means a determination by a health carrier or utilization review entity that an admission, availability of care, continued stay, or other health care service that	

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	14VAC5-216-30	is a covered benefit has been reviewed and, does not meet the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness or is determined to be experimental or investigational and the requested service of payment is denied, reduced, or terminated.	
	14VAC5-216-45	If an issuer fails to adhere to all of the requirements listed with respect to a claim, the claimant is deemed to have exhausted the internal claims and appeals process and may initiate an external review of any remedies available under State law. *The following does not need to be stated as part of the process, but must not be contradicted in the policy:* 1. The internal claims and appeals process will not be deemed exhausted if the violation did not cause harm to the claimant so long as the issuer demonstrates that the violation was for a good cause or due to matters beyond the control of the issuer, and 2. That the violation occurred in the context of an ongoing, good faith exchange of information between the issuer and the claimant. 3. Violations that are part of a pattern by the issuer will not be deemed de minimis.	
	14VAC5-216-60	<u>Ongoing (concurrent care) decisions:</u> 1. Issuer is required to provide continued coverage pending the outcome of an appeal; 2. Issuer must notify enrollee of decision to reduce or terminate an approved course of treatment sufficiently in advance of the reduction or termination to allow enrollee to file an internal appeal and receive a determination prior to the reduction or termination.	
	14VAC5-216-65	<u>Exception Request for Prescription Drugs</u> A covered person or prescriber may request coverage for clinically appropriate non-formulary drugs which shall be reviewed and acted upon within one business day, with a determination provided no later than 72 hours after receipt of the request for a standard exception request. An expedited exception request must be reviewed with a determination provided no later than 24 hours following the request. If the request is denied, the covered person or prescriber may request an external review through the carrier. A coverage determination must be provided no later than 72 hours	

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		following receipt of a standard request and 24 hours following receipt of the request if the original request was an expedited request. If coverage is granted, the carrier must cover the nonformulary drug as a formulary drug for the duration of the prescription (including refills) or for the duration of the exigent circumstances.	
	§ 38.2-3407.9:05	<u>Step Therapy Exception Request</u> A covered person or prescriber may request a step therapy override exception with a determination provided no later than 72 hours after receipt of the request for the step therapy override exception. An expedited exception request must be reviewed with a determination provided no later than 24 hours following the request. If a response by a carrier or utilization review organization is not received within these time periods, the exception or appeal shall be deemed granted.	
External Review	PHSA § 2719 (45 CFR § 147.136) § 38.2-3556 § 38.2-3559 § 38.2-3560 § 38.2-3563 § 38.2-3564 § 38.2-3569 14VAC5-216-45	**External review processes rights and required notices:** External review of an adverse determination for: 1. Medical necessity; 2. Appropriateness; 3. Health care setting; 4. Level of care; or 5. Effectiveness of a covered benefit. External review of adverse determinations for experimental or investigational treatments or services. *Process should reflect the following:* 1. Have at least all of the protections that are available for external reviews based on medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit. 2. Issuers must provide effective written notice to claimants of external review rights in plan materials, and in each notice of adverse benefit determination. 3. Exhaustion of internal appeals is required prior to external review, unless the adverse determination relates to cancer treatment. The process shall be deemed exhausted.	

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		a. If issuer did not meet internal appeal process timelines (with limited exceptions) or otherwise violated the provisions of the appeal process; or b. In cases of an urgent care appeal. 4. Cost of an external review must be borne by the issuer. 5. Claimant cannot be charged a filing fee. 6. Restriction on the minimum dollar amount of a claim is not allowed. 7. Claimant has 120 days to file for external review after the receipt of the right to an external review of an adverse determination (including final internal adverse determination). 8. IRO decision is binding on the issuer. 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. Urgent care: 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. If the IRO's decision was given orally, the IRO must provide written notice of the decision within 48 hours of the oral notification.	

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Enrollment Periods for Qualified Individuals	45 CFR § 146.117 § 38.2-3432.3 § 38.2-3448	**Provide and disclose enrollment periods for qualified individuals:** 30 days from the date of the following: Employee or dependent loss of coverage, including the plan does not provide benefits to individuals outside of the service area; termination of employer contributions; exhaustion of COBRA continuation coverage; marriage, birth, adoption or placement for adoption.	

I hereby certify that I have received the attached health maintenance organizations (Large Group) filing and determined that it is in compliance with the health maintenance organizations (Large Group) checklist.

Signed: _____

Name (please print): _____

Company Name: _____

Date: _____ Phone No: (____) _____ Fax No: (____) _____

E-Mail Address: _____