Form Filing Review Checklist
MAJOR MEDICAL, PREFERRED PROVIDER ORGANIZATIONS, HOSPITAL-MEDICAL-SURGICAL
(INDIVIDUAL)

NOTICE: A health insurance product form filing submission must include: (i) a product-specific checklist, (ii) a mental health and substance use disorder benefits parity checklist, (iii) the essential health benefits (EHBs) checklist for the individual and small group markets; and (iv) the supplemental pediatric dental EHB checklist (for embedded pediatric dental products complying with EHBs in the individual and small group markets). Each required checklist must be completed in its entirety. The failure to submit a complete 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:	
Plan:		Submission Includes Plans Intended for:	
☐	60 % AV (Bronze)	☐	Inside the Exchange
☐	70% AV (Silver)	☐	Outside the Exchange
☐	80% (Gold)	☐	Inside and Outside the Exchange
☐	90% (Platinum)		
☐	Child-Only		
☐	Catastrophic Plan: - Only available to individuals under age 30 or those with hardship/affordability exemption; - Must not meet bronze, silver, gold or platinum AV requirement; - All Essential Health Benefits (EHBs) must be subject to the in-network deductible and no EHB may have any other cost-sharing in-network, EXCEPT a deductible must not apply to preventive services and at least the first 3 primary care physician visits per year; - Cost-sharing must not apply to preventive services; - The in-network deductible must mirror the highest allowed maximum out-of-pocket amount.		
☐	**Student Health Plans**: - Carrier must verify that the prescription drug formulary used for the submitted student health plan(s) is the same as that used in an approved ACA filing. - If not the same, attach the prescription drug template under Supporting Documentation of the student health form filing.		

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	§ 38.2-3500 A 5 14VAC5-100-50 1	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	Group Accident and Sickness forms must be printed with type size of at least 8-point type.	
Table of Contents	14VAC5-100-50 B	Required for policy or more than 3 pages (does not apply to groups with more than 10 members).	
Readability Certification	14VAC5-110-60	Disclose the score, number of words, sentences, and syllables for each form (does not apply to groups with more than 10 members).	
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.	

REVIEW REQUIREMENTS	FEDERAL AND/OR VIRGINIA CITATION	COMMENTS	PAGE NO.
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	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 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."	

REVIEW REQUIREMENTS	FEDERAL AND/OR VIRGINIA CITATION	COMMENTS	PAGE NO.
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 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.	
Limiting Jurisdiction Prohibited	§ 38.2-312 2	Contract shall not deprive courts of Virginia of jurisdiction in actions against insurer.	
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 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.	

REVIEW REQUIREMENTS	FEDERAL AND/OR VIRGINIA CITATION	COMMENTS	PAGE NO.
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	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	Under specified circumstances, issuers shall not exclude coverage from 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.	
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 drug approved by USFDA to treat cancer pain because the dosage is in excess of recommended dosage, if prescribed for a patient with intractable cancer pain.	
Pharmacy Freedom of Choice	§ 38.2-3407.7	For outpatient prescription drug benefits, a plan must allow for freedom of choice of pharmacies, if a non-participating pharmacy or its intermediary agrees in writing to accept reimbursement, including copayment, at the same rates as participating pharmacies.	
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.	
Prescription Drug Formularies	§ 38.2-3407.9:01 B 1, 2, 3	For plans using closed formularies, plans must have a process to allow medically necessary nonformulary prescription drug if the formulary drug is determined by the insurer 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.	

REVIEW REQUIREMENTS	FEDERAL AND/OR VIRGINIA CITATION	COMMENTS	PAGE NO.
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 – 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.	
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.	
Claims Paid to Insureds for Services from Nonpar. Providers	§ 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.	
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.	
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 or 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.	
Prosthetic Devices and Components	§ 38.2-3418.15 A 5	A covered person's coinsurance for in-network prosthetic devices must not be in excess of 30%.	
Entire Consideration/Premium	§ 38.2-3500 A 1	The entire consideration must be expressed in the policy.	
Effective-Terminates	45 CFR § 144.103 45 CFR § 147.104 (b) (2) § 38.2-3500 A 2	The clock time at which the policy becomes effective and terminates must be expressed in the policy.	

REVIEW REQUIREMENTS	FEDERAL AND/OR VIRGINIA CITATION	COMMENTS	PAGE NO.
Payor of Last Resort	§ 38.2-3500 A 7	Each policy must contain a statement regarding the status of the Department of Medical Assistance Services as the payor of last resort.	
Definition of Eligible Family Member	§ 38.2-3500 C § 38.2-3439	The definition recognizes dependent children without regard as to whether such children reside in the same household as the policyowner.	
Important Notice	§ 38.2-3502 A	Each policy must display on the **first page** the specified caution notice. The caution notice should not include the phrase regarding medical history.	
Return of Policy/Free Look	§ 38.2-3502 A	Each policy must display on the **first page** the 10-day free look provision.	
Entire Contract	§ 38.2-3503 A 1	The policy, including endorsements and attached papers, constitutes the entire contract of insurance. No change in the policy is valid until approved by an executive officer of the company, and such approval endorsed on or attached to the policy. No agent has the authority to change or waive policy provisions.	
Time Limit on Certain Defenses Incontestable	§ 38.2-3503 A 2 (2) § 38.2-3503 A 2 (a)	One of these versions must appear in the policy. After 2 years from the date of the policy, only fraudulent misstatements in the application may be used to void the policy or deny a claim. After the policy has been in force for 2 years during the insured's lifetime, the company cannot contest statements in the application.	
Grace Period	§ 38.2-3503 A 3 45 CFR § 156.270	If a renewal premium is not paid on time, it may be paid during the following 31 days. During the 31 days, the policy shall continue in force. Please review the entire statute for variations, and refer to Affordable Care Act (ACA) requirements.	
Reinstatement	§ 38.2-3503 A 4	If a renewal premium is not received within the grace period, the policy will lapse, and the individual may apply for reinstatement based on the company's guidelines.	
Notice of Claim	§ 38.2-3503 A 5	Written notice of claim must be given to the company within 20 days after covered loss starts or as soon as reasonably possible, and should include the name of the insured or claimant, and policy number. The location should be indicated for sending notice to the company.	
Claim Forms	§ 38.2-3503 A 6	The company must provide the claimant with claim forms within 15 days of notification of a claim. If not, proof of loss is met by giving the company a written statement of the nature and extent of the loss within the time limit expressed in the proof of loss provision.	

REVIEW REQUIREMENTS	FEDERAL AND/OR VIRGINIA CITATION	COMMENTS	PAGE NO.
Proof of Loss	§ 38.2-3503 A 7	For periodic payment, written proof of loss must be given to the company within 90 days after the end of each period for which the company is liable. For any other loss, proof must be given within 90 days after the loss. If not reasonably possible to give proof in the time provided, the company shall not reduce or deny a claim if proof is filed as soon as reasonably possible. In any event, except in the absence of legal capacity, proof must be given no later than 1 year from the time specified.	
Time of Payment of Claims	§ 38.2-3503 A 8	After the company receives written proof of loss, it shall pay benefits according to a specified frequency for a specified loss. Benefits for any other loss will be paid as soon as written proof is received.	
Payment of Claims	§ 38.2-3503 A 9	Benefits will be paid to the insured if living, otherwise to the beneficiary or the insured's estate. In the absence of a valid release, the company may pay up to $2,000 to someone whom the company deems entitled.	
Physical Examinations/Autopsy	§ 38.2-3503 A 10	The company, at its own expense, may have the insured examined as often as reasonably necessary while a claim is pending. An autopsy may also be made unless prohibited by law.	
Legal Actions	§ 38.2-3503 A 11	No legal action may be brought to recover on the policy within 60 days after written proof of loss has been given. No legal action may be brought after 3 years from the time written proof of loss is required to be given.	
Change of Beneficiary	§ 38.2-3503 A 12	The insured may change the beneficiary at any time, but the beneficiary's consent is required in the case of an irrevocable beneficiary designation.	
Cancellation by Insured	§ 38.2-3503 A 13	The insured may cancel this policy at any time by written notice to the company. In the event of cancellation, the company shall promptly return the unearned portion of any premium; the earned premium shall be computed pro rata. Cancellation shall be without prejudice to any claim originating prior to the effective date of cancellation.	
Misstatement of Age	§ 38.2-3504 2 § 38.2-3513 B	If the insured's age has been misstated, the benefits will be those the premium paid would have purchased at the correct age. If the age of the insured has been misstated, and if according to the correct age of the insured, the coverage provided by the policy would not have become effective or would have ceased prior to the acceptance of the premium, then the liability of the insurer shall be limited to the refund, upon request, of all premiums paid for the period not covered by the policy.	
Other Insurance with Insurer	§ 38.2-3504 3	If the insured has more than 1 policy with the insurer, the insured may keep the 1 policy he, his beneficiary or his estate has elected, and the company will return all premiums paid for all other such policies. (Please review this statute for variations).	

REVIEW REQUIREMENTS	FEDERAL AND/OR VIRGINIA CITATION	COMMENTS	PAGE NO.
Insurance with Other Companies	§ 38.2-3504 4	If there is other valid coverage providing benefits for the same loss on a provision of service basis or on an expense incurred basis and of which the company has not been given written notice prior to the occurrence or commencement of loss, the only liability under any expense incurred coverage of this policy shall be for such proportion of the loss as the amount which would otherwise have been payable under the policy plus the total of the like amounts under all such other valid coverages for the same loss of which this company had notice bears to the total like amounts under all valid coverages for such loss.	
Insurance with Other Companies	§ 38.2-3504 5	If there is other valid coverage providing benefits for the same loss on other than an expense incurred basis and of which this Company has not been given written notice prior to the occurrence or commencement of loss, the only liability for such benefits under this policy shall be for such proportion of the indemnities otherwise provided under this policy for such loss as the like indemnities of which the company has notice.	
Unpaid Premium	§ 38.2-3504 7	When a claim is paid, any premium due and unpaid may be deducted from the claim.	
Conformity with State Statutes	§ 38.2-3504 9	Any provision of the policy that on its effective date is in conflict with the laws of the state in which the insured resides on that date is amended to conform to the minimum requirements of the laws.	
Definitions	14VAC5-140-40	General terms must be defined in connection with individual accident and sickness coverage to the extent not to conflict with the Affordable Care Act (ACA).	
Continuation of Coverage for Spouse/Deceased Insured	14VAC5-140-50 A	The covered spouse of the insured shall become insured in the event of the insured's death.	
Military Refund	14VAC5-140-50 E	If a policy includes a status type military exclusion, the insurer will provide for a refund of the premium, on a pro rata basis, upon receipt of a written notice of military service.	
Authorized Exclusions	14VAC 5-140-60 F	Permitted exclusions and limitations apply, except where in conflict with the Affordable Care Act (ACA).	
Required Disclosure Provisions	14VAC5-140-80	Rules for all policies apply, except where in conflict with the Affordable Care Act (ACA).	
Renewability	14VAC5-140-80 A 1	Each policy shall contain a renewability provision and it shall appear on the **first page** of the policy.	
Signed Acceptance	14VAC5-140-80 A 2	Any riders or endorsements added to a policy after a date of issue or at reinstatement or renewal which reduce or eliminate benefits for coverage in the policy shall require a signed acceptance by the policyholder.	
Additional Premium	14VAC5-140-80 A 3	Where a separate additional premium is charged for benefits provided in connection with riders or endorsements, such premium charge shall be set forth in the policy.	

REVIEW REQUIREMENTS	FEDERAL AND/OR VIRGINIA CITATION	COMMENTS	PAGE NO.
Usual and Customary	14VAC5-140-80 A 4	A policy which provides for the payment of benefits based on standards described as "usual and customary," "reasonable and customary," or words of similar import shall include an explanation of such terms.	
Policies That Include Issue Ages of 65 or Higher	14VAC5-170-150 E 1	Any policy marketed to persons age 65 or older must contain a notice on the **first page** that discloses that the policy is not a Medicare supplement policy or certificate.	
Dependent Coverage	PHSA § 2714 (45 CFR § 147.120) § 38.2-3409 § 38.2-3411 § 38.2-3411.2 § 38.2-3438 § 38.2-3439	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 the same as for the insured including congenital defects and birth abnormalities. Must notify insurer within 31 days of birth for coverage to continue. 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.	
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	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). **SEE EHB CHECKLIST.**	

REVIEW REQUIREMENTS	FEDERAL AND/OR VIRGINIA CITATION	COMMENTS	PAGE NO.
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 health care professional.	
No Preexisting Condition Exclusions	PHSA § 2704 and § 1255 (45 CFR § 147.108) § 38.2-3444	Issuers may not impose preexisting condition exclusions.	
Emergency Services	PHSA § 2719A (45 CFR § 147.138) § 38.2-3445	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 on 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 § 2719 A (45 CFR § 147.139) § 38.2-3438	"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."	

REVIEW REQUIREMENTS	FEDERAL AND/OR VIRGINIA CITATION	COMMENTS	PAGE NO.
		"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 at the hospital, examination/treatment required to stabilize the patient." "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 form 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	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 health care 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 § 38.2-3407	Providers operating within their scope of practice, license or certification cannot be discriminated against.	
Nondiscriminatory Benefit Design	45 CFR § 156.200 (e) 45 CFR § 156.255 § 38.2-326	QHPs shall not use benefit designs that will have the effect of discouraging the enrollment of individuals with significant health needs in QHPs. QHPs shall not discriminate on the basis of race, color, national origin, disability, age, gender identity, or sexual orientation.	
Cost Sharing Limits	42 USC § 18022 26 USC § 223(c)(2)(A)(ii) 1/9/14 FAQs about Affordable Care Act Implementation (Part XVII) and Mental Health Parity Implementation 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.	

REVIEW REQUIREMENTS	FEDERAL AND/OR VIRGINIA CITATION	COMMENTS	PAGE NO.
		Qualified medical expense 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. 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.	
Guaranteed Renewability	PHSA § 2702 (45 CFR § 147.106 and 148.122) See also § 38.2-3514.2 and § 38.2-3430.7)	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 (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 when renewing into the same policy.	
"Michelle's Law"	PHSA § 2728 (45 CFR § 147.145)	**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.	

REVIEW REQUIREMENTS	FEDERAL AND/OR VIRGINIA CITATION	COMMENTS	PAGE NO.
		☐ 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.	
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.	

REVIEW REQUIREMENTS	FEDERAL AND/OR VIRGINIA CITATION	COMMENTS	PAGE NO.
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 determination 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, 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 <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. **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.	

REVIEW REQUIREMENTS	FEDERAL AND/OR VIRGINIA CITATION	COMMENTS	PAGE NO.
		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 must be made at least 24 hours prior to the expiration of the prescribed period of time/number of treatments. 3. Determination must be made within 24 hours. 4. Notification is required within 24 hours of the claimant's request. **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.	

REVIEW REQUIREMENTS	FEDERAL AND/OR VIRGINIA CITATION	COMMENTS	PAGE NO.
		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. **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);	

REVIEW REQUIREMENTS	FEDERAL AND/OR VIRGINIA CITATION	COMMENTS	PAGE NO.
		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; 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.	

REVIEW REQUIREMENTS	FEDERAL AND/OR VIRGINIA CITATION	COMMENTS	PAGE NO.
		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. <u>Post-service claim</u>: Determination and notification must be made within 60 days after receipt of the claimant's request.	
	14VAC5-216-50	<u>Urgent claim</u>: 1. Determination and notification must 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.	
	§ 38.2-3560 14VAC5-216-20 14VAC5-216-30	An <u>adverse benefit determination</u> 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	

REVIEW REQUIREMENTS	FEDERAL AND/OR VIRGINIA CITATION	COMMENTS	PAGE NO.
		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. An <u>adverse determination</u> 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 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.	

REVIEW REQUIREMENTS	FEDERAL AND/OR VIRGINIA CITATION	COMMENTS	PAGE NO.
	14VAC5-216-65 § 38.2-3407.9:05	<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 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. <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 benefits. External review of adverse determinations for experimental or investigational treatments or services. *Process should reflect the following:*	

REVIEW REQUIREMENTS	FEDERAL AND/OR VIRGINIA CITATION	COMMENTS	PAGE NO.
		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: 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 48 hours of the oral notification.	
Enrollment Periods for Qualified Individuals	45 CFR § 155.410 45 CFR § 155.420 § 38.2-3448	**Provide and disclose enrollment periods for qualified individuals:** **Individual Market** special enrollment – **On Exchange** – 60 days from the date of the following: Loss of minimum essential coverage; marriage, birth, adoption, placement for adoption, placement in foster care; child support order or other court order; material error on exchange; victim or dependent of victim of domestic abuse or spousal abandonment; individual gains citizenship, national, or lawfully present; release from incarceration; unintentional enrollment or non-enrollment in a QHP because of exchange or assister error; violation by QHP of material contract provision; newly eligible for premium tax credit/subsidies; permanent move (conditions); Native American; other exceptional	

REVIEW REQUIREMENTS	FEDERAL AND/OR VIRGINIA CITATION	COMMENTS	PAGE NO.
	45 CFR § 147.104 45 CFR § 155.420 § 38.2-3448	circumstances; new eligibility verification information; Medicaid/FAMIS eligibility determination delay. NOTE: Special enrollment for marriage – only applies if at least one spouse was enrolled in an exchange plan at least 1 day in the 60 days before marriage; or lived abroad for 1 or more days in the 60 days before marriage; or is an American Indian or Alaskan Native. **Individual Market – Off Exchange** – 60 days from the date of the following: Loss of minimum essential coverage; marriage, birth adoption, placement for adoption, placement in foster care, child support order or other court order; material error on exchange; victim or dependent of victim of domestic abuse or spousal abandonment; unintentional enrollment or non-enrollment in a plan because of error; violation by plan of material contract provision; newly ineligible for premium tax credit/subsidies; permanent move (conditions); Medicaid/FAMIS eligibility determination delay. NOTE: Special enrollment for marriage – only applies if at least one spouse was enrolled in an exchange plan at least 1 day in the 60 days before marriage; or lived abroad for 1 or more days in the 60 days before marriage; or is an American Indian or Alaskan Native.	

Form Filing Review Checklist
MAJOR MEDICAL, PREFERRED PROVIDER ORGANIZATIONS, HOSPITAL-MEDICAL-SURGICAL
(INDIVIDUAL)

I hereby certify that I have received the attached major medical, preferred provider organizations, hospital-medical-surgical (Individual) filing and determined that it is in compliance with the major medical, preferred provider organizations, hospital-medical-surgical (Individual) checklist.

Signed: _____

Name (please print): _____

Company Name: _____

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

E-Mail Address: _____

Reset Print