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Review Requirements Checklist
HEALTH SERVICES PLANS
(INDIVIDUAL AND SMALL GROUP)

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 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. Access to Administrative Letters, Administrative Orders, Regulations and Laws is available at: Virginia SCC - Administration of Insurance Regulation in Virginia

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			
Source of Filing	14 VAC 5-101-40	Filings shall be submitted in SERFF or submitted in writing to the Commission. If filed by a third-party, filing authorization must be included.	
Filing Description	14 VAC 5-101-50 C 1	Filing description must include the type of insurance form, including a description of the form and the market for which the form is intended; intentions to concentrate on a specialized market should be noted.	
	14 VAC 5-101-50 C 2	Filing description must include the form number of each form that is being filed.	
	14 VAC 5-101-50 C 3	Filing description must state whether submitted form is new, or if replacing, revising, or modifying a previously approved form and the exact changes that are intended.	
	14 VAC 5-101-50 C 4	Filing description must identify any change in benefits and indicate whether the change affects premium rates for the form.	
	14 VAC 5-101-50 C 5	Filing description must state if approval of a form submitted has been withdrawn by another regulatory body and the reasons for such a withdrawal.	
	14 VAC 5-101-50 F	Any form filed that is to be used with a previously approved form, including an application, shall identify the form number, approval date, and SERFF or state tracking number in the new filing.	
	14 VAC 5-101-50 G	Any amendment, endorsement, or rider that intends to revise a previously approved form shall be accompanied by the previously approved form filed as supporting documentation.	
HELP TIP:		If a form filing is submitted as new in Virginia, but was previously disapproved, withdrawn or rejected in Virginia, please provide details such as the SERFF or State tracking information, form number, and the date that the form filing was disapproved, withdrawn or rejected if available.	
Forms			
Form Number	14 VAC 5-101-60 1	Form Number must appear in the lower left-hand corner of the first page of the form. It shall consist of numbers, letters, or a combination of both. The form number shall distinguish the form from all other forms used by the company.	
Company Name and Address	14 VAC 5-101-60 2	The full licensed name of the company, including the address of the home office, shall appear in prominent print at the top of the cover page of any policy, application, or enrollment form. The full licensed name of the company shall appear in prominent print on all other forms.	
Marketing or logo	14 VAC 5-101-60 3	A marketing name or logo also may be used on the form, provided that the marketing name or logo does not mislead as to the identity of the filing company.	

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	14 VAC 5-101-60 4	The cover page of a policy also shall include the address of an office that will administer the policy, if different from the home office, a company telephone number, and company website address.	
Final Form – John Doe	14 VAC 5-101-60 5	Form must be submitted in “final form” and in “John Doe fashion” to indicate its intended use.	
Electronic Version	14 VAC 5-101-60 6	Each form that is to be used in an electronic version shall be filed in a format that matches the electronic version exactly.	
Readability	14 VAC 5-101-70 A	Each form submitted for review or approval shall be written in simplified language, logically and clearly arranged, and printed in a legible format and understandable to a person of average intelligence without special insurance knowledge or training.	
	14 VAC 5-101-70 B	A policy of more than three pages shall include a table of contents listing the principal sections and provisions and the pages on which they are found.	
	14 VAC 5-101-70 C	Defined words and terms shall be placed in a separate definition section that is clearly identified, unless only used in one section.	
	14 VAC 5-101-70 D	A policy shall be divided into logically arranged sections with an appropriately named caption or heading for ease in locating desired content. Captions and headings shall be clearly set apart from the general text.	
	14 VAC 5-101-70 E	Any form submitted for review or approval shall be printed in at least 10-point type size.	
	14 VAC 5-101-70 F	Any policy shall achieve a minimum Flesch reading ease score of 50 or an equivalent score using another comparable test, unless otherwise specified by statute, or an exception requested pursuant to 14 VAC 5-101-70 G.	
Variability	14 VAC 5-101-80	Use of variable bracketed information shall be limited. Use of brackets within brackets is not permitted. Each instance of variable text shall appear in brackets on a form and shall be separately and completely explained in detail in a Statement of Variability document. Each explanation of variability shall appear in the same order that it appears on the form. Additional guidance is attached to SERFF General Instructions.	
Certificate of Compliance	14 VAC 5-101-110	Each form filing shall contain a Certificate of Compliance signed by an officer of the company certifying the Flesch reading ease score of at least 50; that a review of the form has been conducted and is consistent and complies with the requirements of Title 38.2 and applicable rules and regulations; and a statement that failure to comply with these requirements will result in disapproval of the filing.	

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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. Documentation 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. 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 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	Contract/EOC 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 contract/EOC 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 recommended dosage, if prescribed for a patient with intractable cancer pain.	
Ambulance Services	§ 38.2-3407.9 A, B	Contracts 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 emergency 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, plan must have a process to allow medically necessary non-formulary prescription drug if the formulary drug is determined by the health services plan and physician to be inappropriate therapy. Requests must be acted on within one business day of receipt. See specific subsections of the Code.	
Exclusion of Prescription Drug Coverage Prohibited	§ 38.2-3407.9:02	Prescription drugs shall not be excluded from coverage solely on the basis of the length of time since the drug obtained FDA approval.	

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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	For a period of at least 90 days from the date of the notice of the provider's termination, except when the provider is terminated for cause, the carrier shall permit the provider to treat enrollees who were in an active course of treatment prior to the notice of termination and request to continue receiving health care services from the provider.	
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.	
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 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.	
Inter-Hospital Transfer of Infant and Mother	§ 38.2-3407.11:5	Plan shall not require pre-authorization for the inter-hospital transfer of a newborn with life-threatening emergency condition or the mother of such infant.	
COB Notice of priority of coverage	§ 38.2-3407.13:1	COB provision shall be prominent in enrollment materials.	
Claims Paid to Insureds for Services from Nonpar. Providers	§ 38.2-3407.13:2	The EOC 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/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.	
Prescription Insulin Drugs	§ 38.2-3407.15:5	Cost-share for covered prescription insulin drugs cannot exceed $50 per 30-day supply.	

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Orally Administered Cancer Chemotherapy Drugs	§ 38.2-3407.18	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.	
Obstetrical Services (Group Only)	§ 38.2-3414	Deductible and coinsurance factors for inpatient and physician obstetrical services shall be no less favorable than for physical illness generally.	
Exclusion or Reduction of Benefits	§ 38.2-3415	No plan shall reduce or exclude any benefits because benefits have been payable under any individual policy.	
Prosthetic Devices and Components	§ 38.2-3418.15	A covered person's coinsurance for in-network prosthetic devices must not be in excess of 30%.	
Autism	§ 38.2-3418.17	Plan shall provide coverage for the treatment of autism as required by this section. These benefits shall be provided without separate deductible, copayment, coinsurance; or any visit limits or lifetime limits.	
Pharmacy Freedom of Choice	§ 38.2-4209.1	If a plan has outpatient prescription drug benefits, **including specialty drugs**, a plan or its **pharmacy benefits manager** (PBM) must allow for freedom of choiceof pharmacies, if non-participating pharmacies agree in writing to accept reimbursement, including copayment, at the same rates as participating pharmacies.	
Dependent Coverage	PHSA § 2714 (45 CFR § 147.120) § 38.2-3409 § 38.2-3411 § 38.2-3411.2 § 38.2-3438 § 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 same as for the insured including congenital defects and birth abnormalities. May require that insurer be notified. 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.	

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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). **See EHB checklist.**	
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.	
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 health care professional who is available to accept such individual. 2. A participating health care 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.	
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	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 provided regardless of the final diagnosis and without requirements for prior authorization or any requirement that	

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		service be provided by a participating provider. Cost-sharing (copay and coinsurance amounts) must not differ from the in-network level. Any cost-sharing for out-of-network emergency services will apply to the in-network deductible and maximum out-of-pocket.	
Emergency Services Definitions	PHSA § 2719A (45 CFR § 147.138) § 38.2-3438	"Emergency medical condition means, regardless of the final diagnosis rendered to a covered person, 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."	
Balance Billing for Out-of-network Providers	§ 38.2-3445.01 14VAC5-405	Out-of-network provider shall not balance bill an enrollee for; • emergency services provided to an enrollee or • nonemergency services provided to an enrollee at an in-network facility if the nonemergency services involve surgical or ancillary services provided by an out-of-network provider. An enrollee that receives services described above is required only to pay the in-network cost-sharing requirement specified in the enrollee's or applicable group health plan contract. The enrollee's obligation shall be determined using the carrier's median in-network contracted rate for the same or similar service in the same or similar geographical area. The carrier shall provide an explanation of benefits to the enrollee and the out-of-network provider that reflects the cost-sharing requirement determined under this subsection. The obligation of an enrollee in a health benefit plan that uses no median in-network contracted rate for the services provided shall be determined as provided in § 38.2-3407.3.	
Provider Nondiscrimination	PHSA § 2706 § 38.2-4221	Specified providers operating within their scope of practice, license or certification cannot be discriminated against.	
Nondiscriminatory Benefit Design	45 CFR § 156.200(e) and 45 CFR § 156.225 § 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, sex, gender identity, or sexual orientation.	

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"Michelle's Law"	PHSA § 2728 (45 CFR § 147.145) § 38.2-3525 E (Small Group)	**Coverage for dependent student on <u>medically necessary leave of absence</u> ("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. ☐ 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. ☐ <u>Medically necessary leave of absence</u> means: a leave of absence or change of enrollment of a dependent child from a postsecondary education institution that: 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.	

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Cost-Sharing Limits	42 USC § 18022 26 USC § 223(c)(2) (A) (ii) 2021 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 **($9,100 individual/$18,200 family for 2022).** 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 other than those services described in § 38.2-3445.01. 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 2021 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 § 38.2-3430.7)	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, 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.**	
Renewability (Group Only)	§ 38.2-3432.1 2015 Letter to Issuers in the Federally-facilitated Marketplace	Each insurer shall renew or continue in force coverage with respect to all insureds at the option of the employer with specific exceptions listed in this section of the Code. On the SHOP, carriers must renew a group even if it does not meet Exchange participation requirements if that group renews during the open enrollment period.	

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Renewability of Individual Health Insurance Coverage	§ 38.2-3514.2 § 38.2-3430.7	Renewal is at the option of the individual, except for specific reasons expressed in the statutes.	
Waiting Periods (Group Only)	§ 38.2-3452	Waiting periods for group enrollees shall be no longer than 90 days before being eligible for coverage.	
Cancellation by Insured (Individual Only)	§ 38.2-3503.13	The enrollee may cancel this policy at any time by written notice to the company. In the event of cancellation, the company shall 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.	
Notice upon Termination (Group Only)	§ 38.2-38.2-3542 A	Certain employers shall give written notice of participating employees in the event of termination or upon the receipt of notice of termination of any such policy no later than 15 days after the termination of a self-insured plan or receipt of the notice of termination.	
Termination Notice Employer (Group Only)	§ 38.2-3542 C	Notice must be given to employer at least 15 days prior to terminating contract due to non-payment of premiums.	
Continuation (Group Only)	§ 38.2-3541	Each policy shall contain a provision that sets forth a provision for continuation of coverage. Please read this section of the Code for complete details of continuation requirements.	
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	**Specific requirements to be included in or attached to policy:**	

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	§ 38.2-3570	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, 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.	

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		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. **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.	

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	§ 38.2-3559 § 38.2-3562 § 38.2-3563 § 38.2-5803 14VAC5-216-30 14VAC5-216-40 Administrative Letter 2011-05	**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. **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;	

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		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; 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.	

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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. <u>Post-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.	

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	14VAC5-216-50	Urgent claim: 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 adverse benefit determination means a denial, reduction, 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. 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 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.	

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	14VAC5-216-45 14VAC5-216-60 14VAC5-216-65	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 too minor to merit consideration. <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. <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.	

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	§ 38.2-3407.9:05	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.	
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. 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.	

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		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.	
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 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.	

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	45 CFR § 146.117 § 38.2-3432.3 § 38.2-3448	**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.	
Enrollment Periods for Qualified Individuals	45 CFR § 155.725 45 CFR § 155.420 § 38.2-3432.3 § 38.2-3448 45 CFR § 146.117 § 38.2-3432.3 § 38.2-3448	**Provide and disclose enrollment periods for qualified individuals:** **SHOP** - Special enrollment periods available for 30 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 QHP because of exchange or assister error; violation by QHP of material contract provision; permanent move (conditions); Native American; other exceptional circumstances; Medicaid/FAMIS eligibility determination delay. Special enrollment for Medicaid/FAMIS – 60 days. **SMALL GROUP** - 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.	

Review Requirements Checklist
HEALTH SERVICES PLANS
(INDIVIDUAL AND SMALL GROUP)

I hereby certify that I have received the attached health services plan (Individual and Small Group) filing and determined that it is in compliance with the health services plans (Individual and Small Group) checklist.

Signed: _____

Name (please print): _____ _____

Company Name: _____

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

E-Mail Address:_____