Review Requirements Checklist
GROUP - HEALTH SERVICES PLANS
(See Separate Federal Market Reform Healthcare Act Checklist When Applicable)

REVIEW REQUIREMENTS	REFERENCES	COMMENTS
General Filing Requirements		
Transmittal Letter	14 VAC 5-100-40	**For Paper Filings:** Must be submitted in duplicate, describing each form, its intended use and kind of insurance provided.
	14 VAC 5-100-40 1	Forms submitted and described in transmittal letter must have a number that consists of digits, letters or a combination of both.
	14 VAC 5-100-40 2	Must clearly indicate if forms are replacements, revisions, or modification of previously approved forms and set forth the exact changes that are intended.
	14 VAC 5-100-40 3	Certificate of compliance signed by General counsel, or officer of company, or attorney, or actuary representing company is required.
	14 VAC 5-100-40 5	Description of market for which the form is intended.
	14 VAC 5-100-40 6	**For Paper Filings:** At least one copy of each form must be included in the filing. A duplicate copy of forms must be submitted if the company wants a "stamped" copy of forms for its records. A stamped self-addressed return envelope is required. The letter of transmittal must be addressed to: State Corporation Commission, Bureau of Insurance, P. O. Box 1157, Richmond, VA 23218.
	Admin Letter 1983-7	Must include the name and Individual NAIC number of the company for which the filing is made.
Form Number	14 VAC 5-100-50 1	Form number must appear in the lower left-hand corner of the first page of the form.
Full & Proper Corporate Name	14 VAC 5-100-50 2	Full and proper corporate name (including Inc.) 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 to be Used	14 VAC 5-100-50 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.
General Provisions		
Unfair Discrimination	§ 38.2-508	Plan cannot discriminate unfairly between individuals of the same class or essentially the same hazard with regards to benefits, eligibility, issues or termination of insurance.
Medicaid Eligibility Prohibited	§ 38.2-508.3	When considering eligibility, Medicaid eligibility cannot be a factor
Subrogation	§ 38.2-3405 A	Policy cannot allow subrogation of any person's right to recovery for personal injuries from a third party.
COB/Liability Coverage Prohibited	§ 38.2-3405 B	No plan shall require 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 worker comp laws or govt. programs nor shall it prohibit coordination of benefits between insurance contracts.
Worker's Compensation Exclusion	§ 38.2-3405 D	Issuer shall not exclude coverage from any medical condition whenever benefits payable under workers compensation are excluded from coverage.

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Ambulance Services	§ 38.2-3407.9 B	If policy provides for ambulance services, any such person shall receive reimbursement for such services directly from the issuer of the policy, when the issuer is presented with an assignment of benefits by the person providing such services.
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.
Claims Paid to Insureds for Services from Nonpar. Physicians	§ 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.
Exclusion or Reduction of Benefits	§ 38.2-3415	No plan shall reduce or exclude any benefits because benefits have been paid or are payable under any individual policy.
Group A&S Definitions	§ 38.2-3521.1	This section provides that no policy or group accident and sickness insurance shall be delivered in this Commonwealth unless it conforms to one of the listed definitions.
Non-Defined Groups	§ 38.2-3522.1	Group A&S insurance offered to a resident of this Commonwealth under a policy issued to a group other than one described in § 38.2-3521.1 shall be subject to certain requirements for policies issued in Virginia or in other states.
Policies Issued Outside of Virginia	§ 38.2-3523.2	Policies issued outside of this Commonwealth, providing coverage to residents of this Commonwealth, that do not qualify under §§ 38.2-3521.1 or 38.2-3522.1 shall be subject to the statutory requirements of this title.
Dependent Coverage Spouse & Children	§ 38.2-3525	Coverage may be extended to insure the spouse and any child under 19 or who is a dependent and a full time student under age 25, without regard whether the child resides in the same household.
Claim Experience (30 days)	§ 38.2-3540.1	Each policy must contain a provision that a complete record of the policyholders claim experience shall be provided, upon request. Must be made available no less than 30 days prior to the date premium or contract terms of the policy may be amended.
Conversion or continuation Option 1 Individual Policy App. Option 2	§ 38.2-3541	Each policy shall contain a provision that sets forth 2 options regarding conversion or continuation of coverage.
*Reimbursement Certain Practitioners	§ 38.2-4221	Reimbursement for service that may be legally performed by a person licensed in this Commonwealth shall not be denied because the service is rendered by the licensed practitioner. (See list of practitioners)
Eligibility		
Renewability	§ 38.2-3432.1	Each insurer shall renew or continue in force coverage with respect to all insureds at the option of the employer with numerous exceptions listed in this section of the Code.
Availability	§ 38.2-3432.2	Coverage must be offered and made available to all eligible employees as outline in this section.

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Pre-Existing Conditions		
Pre-Existing Condition	§ 38.2-3432.3 A 1	Each policy shall contain a definition of a pre-existing exclusion that relates to a condition regardless of the cause of the condition for which medical advice, diagnosis; care or treatment was recommended or received within the 6-month period ending on the enrollment date.
Pre-Existing Exclusion	§ 38.2-3432.3 A 3 & B	Such exclusion extends for a period of not more than 12 months after the enrollment date; however a health insurer may not impose any pre-existing condition exclusion for an individual who, as of the last day of the 30-day period beginning with the date of birth, is covered under credible coverage.
Late Enrollee	§ 38.2-3432.3 A 3 & N	A late enrollee may be excluded from coverage for up to 12 months or may have a pre-existing condition limitation apply for up to 12 months; however, no enrollee shall be excluded from some or all coverage for more than 12 months.
Credible Coverage Period	§ 38.2-3432.3 C	A period of credible coverage shall not be counted if, after such period and before the enrollment date, there was a 63-day period during all of which the individual was not covered under any credible coverage.
Eligibility to Enroll	§ 38.2-3436	Any insurer offering group health coverage may not establish rules for eligibility of any individual to enroll under the terms of the plan based on any health status-related factors.
Termination		
Term Notice Employer	§38.2-3542	Notice must be given to employer at least 15 days prior to terminating contract due to non-payment of premiums.
Notice Requirements		
Notice Policy Information	§ 38.2-305 B	Plan must contain or have the notice attached as stated in this section. Plans must have additional statement: "We recommend that you familiarize yourself with our grievance procedure, and make use of it before taking any other action."

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Basic Health Insurance Coverage (products issued to small employers that exclude one or more state mandated benefits).	§ 38.2-3406.1	The intended purpose of any and all forms developed in accordance with § 38.2 3406.1 must be clearly disclosed when the forms are submitted to the Bureau for approval. Policy forms, subscription contracts, certificate forms or other evidences of coverage furnished to small employers and their employees must prominently disclose any and all state-mandated health benefits that the policy or subscription contract does not provide. (See footnotes below for state-mandated health benefits). Application and enrollment forms must include the following: A prominent disclosure that the policy or contract is not required to provide all state-mandated health benefits, along with the specific state-mandated health benefits that the policy or subscription contract does not provide; and A clear description of any and all eligibility requirements applicable to each employee.
Provider Continuation – Active Treatment	§ 38.2-3407.10.F 1	Terminated provider may continue to treat enrollee for 90 days, if enrollee is under active course of treatment with provider, enrollee requests such continuing care, & provider has not been terminated for cause.
Provider Continuation – Pregnancy	§ 38.2-3407.10.F 2	Terminated provider may continue to treat enrollee who has entered 2nd trimester of pregnancy at the time of provider's termination, except when provider is terminated for cause. Treatment may continue through postpartum care.
Provider Continuation – Terminal Illness	§ 38.2-3407.10.F 3	Terminated provider may continue to treat enrollee who is determined to be terminally ill at the time of provider's termination, except when the provider is terminated for cause. Treatment may continue for duration of enrollee's life for care of terminal illness.
Notice of Benefits Reduction	§ 38.2-3407.10 M	Carriers shall provide Group 60 day notice before reductions in benefits take effect, Group then has 30 days to notify enrollee. Notice must be separate and distinct and not combined with any other notices or marketing materials.
BOI and DOH Notice	§ 38.2-5803 A 4	Each policy shall contain a notice: "This Company is subject to regulation in this Commonwealth by the SCC BOI pursuant to Title 38.2 and by the VA Dept. of Health pursuant to Title 32.1."
Ombudsman Notice	§ 38.2-5803 A 5	A prominent notice in the EOC stating: "If you have any questions regarding an appeal or grievance concerning the health care services that you have been provided which have not been satisfactorily addressed by you 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.

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Adverse Decision Appeal	§ 32.1-137.9 F	Plan shall contain a clear & complete stmt. of procedures for reconsideration of an adverse decision and the process of appeal from an adverse decision.
Mandated Benefits or Provisions		
*Prohibited Denial of Certain Prescription Drugs	§ 38.2-3407.5	Plan must contain language indicating benefits will not be denied for any drug approved by U.S.F.D.A. to treat cancer because the drug has not been approved by U.S.F.D.A. for that specific type of cancer for which drug has been prescribed, if the drug is recognized as safe & effective treatment of that specific type of cancer in standard reference compendia.
*Coverage for Prescription Contraceptives	§ 38.2-3407.5:1	Plan that contains coverage for prescription drugs must offer coverage for contraceptive drugs & devices. Such coverage must include both drugs & devices.
*Denial of Benefits for Certain Prescription Drugs Prohibited	§ 38.2-3407.6:1	EOC must contain language indicating benefits will not be denied for any drug approved by U.S.F.D.A. to treat cancer pain because the dosage is in excess of recommended dosage, if prescribed for a patient with intractable cancer pain.
*Prescription Drug Formularies	§ 38.2-3407.9:01 B	For plans using closed formularies, must have a process to allow medically necessary nonformulary prescription, drug if the formulary drug is determined by the HMO to be inappropriate therapy. Requests must be acted on within one business day of receipt.
*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.
*Access to Obstetricians/ Gynecologists	§ 38.2-3407.11	Policies that include coverage for obstetrical or gynecological services shall permit any covered female of age thirteen or older direct access, as provided in this section of the Code, to the health care services of a participating obstetrician-gynecologist (i) authorized to provide services under the policy, contract or plan and (ii) selected by such female.
*Access to Specialists – Standing Referrals	§ 38.2-3407.11:1	Notice that plan permits enrollee a standing referral, as provided in subsection B.
*Standing Referrals for Cancer Patients	§ 38.2-3407.11:2	Notice that plan provides a procedure to permit enrollee diagnosed with cancer to have standing referral to board-certified physician in pain management or oncologist.
*Breast Cancer Underwriting and Preexisting Conditions Restrictions	§ 38.2-3407.11:3	Plan is prohibited from denying the issuance or renewal of coverage, or from canceling such coverage, or from including the exception or exclusion of benefits based solely on the members having a high risk of breast cancer or having had breast cancer, and having been cancer free for 5 years or more.
*Obstetrical Care – Nondiscriminatory	§ 38.2-3407.16	Plan with obstetrical benefits must provide such benefits with duration limits, deductibles, coinsurance factors, & copayments no less favorable than physical illness generally.

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Handicapped Child Coverage	§ 38.2-3409	Upon termination due to age, coverage will be continued for: (1) Persons incapable of self-sustaining employment by reason of mental retardation or physical handicap; and (2) Chiefly dependent on the insured for support & maintenance. Additional premium may be charged based upon class of risks.
*Newborn Children Coverage	§ 38.2-3411	Plan shall provide newborn coverage from the moment of birth. Coverage must be same as for the insured including congenital defects and birth abnormalities. Must notify Insurer within 31 days of birth for coverage to continue.
*Child Health Supervision Services (Optional)	§ 38.2-3411.1	Each plan shall offer and make available child health supervision services as outlined in this section.
*Adopted Children	§ 38.2-3411.2	An adopted child shall be eligible for coverage from the date of adoptive or parental placement with insured for purpose of adoption.
*Coverage for Childhood Immunizations	§ 38.2-3411.3	Plan must provide coverage for all routine immunizations for covered children from birth to 36 months of age.
*Coverage for Infant Hearing Screening and Audiological Examinations	§ 38.2-3411.4	Plan must provide coverage for infant hearing screenings and all necessary audiological examinations pursuant to § 32.1-64.1, using technology approved by the U.S.F.D.A. and, as recommended by the national Joint Committee on Infant Hearing. Coverage must include any follow-up audiological examinations recommended by a physician or audiologist and performed by a licensed audiologist to confirm the existence or absence of hearing loss.
*Coverage for Mental Health and Substance Abuse	§ 38.2-3412.1 A	Definitions of Mental health and substance abuse services and facilities.
*Adult Inpatient Treatment	§ 38.2-3412.1 B 1	Plan must provide mental and nervous and substance abuse inpatient treatment for an adult in a hospital, mental health treat center, alcohol or drug rehab facility for a minimum of 20 days per contract or policy year.
*Child Inpatient Treatment	§ 38.2-3412.1 B 2	Plan must provide same services as above except for a minimum of 25 days per policy or contract year. Child is a person under 19 years of age.
*Partial Hospitalization	§ 38.2-3412.1 B 3	Up to 10 days of the above inpatient benefit may be converted to a partial hospitalization benefit at a rate of 1.5 days partial Hospitalization to one day of inpatient benefits.
*Outpatient – 20 Visits	§ 38.2-3412.1 C	Plan must also provide outpatient mental and nervous benefits for a minimum of 20 visits per policy or calendar year.
*Coverage for Biologically Based Mental Illness	§ 38.2-3412.1:01	Coverage for biologically based mental illnesses must be considered the same as any other illness. Plan should indicate those nine diagnoses so categorized.

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*Obstetrical Benefits – Coverage for Postpartum Services	§ 38.2-3414.1	Plan providing benefits for obstetrical services must have coverage for postpartum services as provided in subsection B.
*Coverage for Victims of Rape/Incest	§ 38.2-3418	Policies or contracts which provide benefits as a result of an accident shall be construed to include benefits for pregnancy following an act of rate of an insured or subscriber.
●Coverage for Mammograms	§ 38.2-3418.1	Plan must provide availability of coverage for one mammogram to persons age 35 through 39, one mammogram biennially to persons age 40 through 49 & one mammogram annually to persons age 50 & over.
●Pap Smears/Gynecologic Cytology Screening	§ 38.2-3418.1.2	Plan must include coverage for an annual pap smear & gynecologic cytology screening.
*Bone/Joint Coverage TMJ Procedures	§ 38.2-3418.2	Plan may not exclude nor impose limits on treatment involving any bone or joint of the head, neck, face, or jaw that is more restrictive than limits on coverage to other bones or joints.
*Hemophilia & Congenital Bleeding Disorders	§ 38.2-3418.3	Plan must provide coverage for treatment of hemophilia and congenital bleeding disorders. Benefits must include treatment of routine bleeding episodes, purchase of blood products and blood infusion equipment for home treatment.
*Reconstructive Breast Surgery	§ 38.2-3418.4	Plan must provide coverage for reconstructive breast surgery following mastectomy as specified in subsections B & C.
*Early Intervention Services	§ 38.2-3418.5	Plan must provide coverage for early intervention services with limitation of $5000 per enrollee per year. Coverage is for dependents from birth to age 3.
*Minimum Hospital Stay for Mastectomy/Lymph Node Dissection Patients	§ 38.2-3418.6	Plan must provide coverage for minimum inpatient hospital stays for radical or modified mastectomy or no less than 48 hours and not less than 24 hours for total mastectomy or partial mastectomy with lymph node dissection.
●PSA Testing & Digital Exams	§ 38.2-3418.7	Plan must provide coverage for PSA testing and digital examinations for persons age 50 and over or age 40 if at high risk for prostate cancer.
●Colorectal Cancer Screening	§ 38.2-3418.7:1	Plan must provide coverage for colorectal cancer screening as specified in subsection B.
*Clinical Trials for Cancer	§ 38.2-3418.8	Plan must provide benefits for patient costs incurred during participation in clinical trials for treatment studies on cancer.
*Minimum Hospital Stay for Hysterectomy	§ 38.2-3418.9	Plan must provide coverage for minimum hospital stay of not less than 23 hours for a laparoscopy- assisted vaginal hysterectomy or 48 hours for a vaginal hysterectomy.
*Diabetes Coverage	§ 38.2-3418.10	Plan must provide coverage for diabetes benefits for equipment, supplies and in-person outpatient self-management training for as specified in section.

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*Hospice Care	§ 38.2-3418.11	Plan shall provide hospice services including palliative and supportive physical, psychological, psychosocial and other health services to individuals with a terminal illness whose prognosis is death within six months and who elects to receive palliative care instead of curative care.
*Hospitalization for Anesthesia & Dental Procedures	§ 38.2-3418.12	Plan shall provide for medically necessary general anesthesia and hospitalization or facility charges to provide outpatient surgical procedures for dental care. This may include general anesthesia and admission to a hospital or outpatient surgical facility to effectively provide dental care and enrollee is 1) under age 5, or 2) is severely disabled, or 3) has a medical condition requiring hospitalization or surgical facility and general anesthesia for dental care or treatment.
*Treatment of Morbid Obesity	§ 38.2-3418.13	Offer and make available coverage for the treatment of morbid obesity through gastric bypass surgery or other methods recognized by the National Institute of Health as effective.
*Lymphedema	§ 38.2-3418.14	Policies or contracts shall provide coverage for lymphedema.
*Prosthetic Devices and Components	§ 38.2-3418.15	Offer and make available coverage for the health care services for medically necessary prosthetic devices, their repair, fitting, replacement, and components.
*Telemedicine Services	§ 38.2-3418.16	Coverage shall be provided for health care services through telemedicine services.
*Coverage for Autism Spectrum Disorder	§ 38.2-3418.17	Coverage and the treatment for the diagnosis of autism spectrum disorder from age two through age six shall be provided, subject to annual maximum benefit limitations set forth in subsection K of this section of the Code. See Code regarding coverage for services beyond age six.
Pharmacy Freedom Choice	§ 38.2-4209.1	If Plan has Rx drug benefits, plan must allow for freedom of choice of pharmacies if non-participating pharmacies agree in writing to accept reimbursement at the same rates as participating pharmacies including copayment.
●Reimbursement Certain Practitioners	§ 38.2-4221	Insurer cannot refuse to allow or to pay to a subscriber for all or any part of health services rendered by practitioners listed in this section, if 1) services are provided for by the contract, and 2) and are services which the practitioner is licensed to render in VA.

* = Optional state-mandated health benefits under § 38.2-3406.1
● = Required state-mandated health benefits under § 38.2-3406.1

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Access to Administrative Letters, Administrative Orders, Regulations and Laws is available at:
http://www.scc.virginia.gov/boi/laws.aspx

The Life and Health Division, Forms and Rates Section handles health services plans for group insurance. Please contact this section at (804) 371-9110 if you have questions or need additional information about this line of insurance.

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I hereby certify that I have reviewed the attached health services plans for group insurance and determined that it is in compliance with the health services plans for group insurance checklist.

Signed: _____

Name (please print): _____

Company Name: _____

Date: _____ Phone No: ( ) _____ FAX No: ( )_____

E-Mail Address: _____