Review Requirements Checklist
HEALTH MAINTENANCE ORGANIZATIONS
(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 for each filing, 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 modifications of previously approved forms, and describe the exact changes that are intended.
	14 VAC 5-100-40 3	Certification of Compliance signed by General Counsel or officer of company, or attorney or actuary representing company is required.
	14 VAC 5-100-40 5	Description of market for which the forms are intended.
	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.
	Administrative Letter 1983-7	Must include the name and individual NAIC number of the company for which the filing is made.
Additional SERFF Filing Requirements	***Administrative Letter 2012-03***	***Additional SERFF filing requirements must be met as specified below for life and health forms and rate filings. Failure to provide the applicable information will result in a "rejected" filing.***
General Information – Filing Description		(i) Description of each form by name, title, edition date, other; 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		(iv) A statement as to whether any other regulatory body has withdrawn approval of the form because the form contains one or more provisions that were deemed to be misleading, deceptive or contrary to public policy.
HELP TIP:		If a form or rate filing is submitted as new in Virginia, but was previously disapproved or withdrawn in Virginia, please provide details such as the tracking information, form number, and the date that the form or rate filing was disapproved or withdrawn, if available.

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Rate Changes		(i) Specify the number of affected policyholders.
		(ii) Provide the reason(s) for the proposed change(s).
		(iii) Include a statement regarding an increase, decrease, revision of former rates.
		(iv) Specify the percentage amount(s) of the change(s).
General Provisions		
Subrogation	§ 38.2-3405	Policy cannot allow subrogation of any person's right to recovery for personal injuries from a third party.
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.
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.
Definition – Emergency Service	§ 38.2-4300	Must be essentially the same as it appears in this section.
EOC Must Be Provided	§ 38.2-4306 A 1	Each subscriber shall be entitled to an Evidence of Coverage (EOC).
Misleading Statements	§ 38.2-4306 A 3	No EOC shall contain statements that are unjust, unfair, untrue, inequitable, misleading, deceptive or misrepresentative.
Complete Statement of Benefits	§ 38.2-4306 A 4(a)	An EOC shall contain a complete summary of health care services and other benefits the enrollee is entitled.
States Limits and Copayments	§ 38.2-4306 A 4 (b)	An EOC shall contain any limits on services, including deductibles and copayments.
Describes Service Delivery	§ 38.2-4306 A 4 (c)	EOC must contain where and in what manner services may be obtained.
Contributory/Non-contributory	§ 38.2-4306 A 4 (d)	EOC must state if plan is contributory or noncontributory if group plan, and premium amount for individual contracts.
Complaint Procedures	§ 38.2-4306 A 4 (e)	EOC must contain enrollee complaint procedures.
Provider List/Service Area	§ 38.2-4306 A 4 (f)	Provider list and service area description must be presented with EOC, if information is not given to subscriber at enrollment. Provider lists and service area description must be available on request or provided at least annually.
Freedom to Choose PCP	14 VAC 5-211-140	Enrollee may choose any available participating Primary Care Physician.
Arbitration	14 VAC 5-211-210 B 7	Plan may not limit arbitration, if amount is $250 or more. If enrollee agrees to binding arbitration. Acceptance shall not be prior to time complaint is registered or subsequent to initial resolution
Unfair Discrimination	14 VAC 5-211-240 A	Plan may not unfairly discriminate against any enrollee on the basis of the age, sex, health status, race, color, creed, national origin, ancestry, marital status, or lawful occupation of the enrollee. HMO may set rates in accordance with such relevant actuarial data.

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REVIEW REQUIREMENTS	REFERENCES	COMMENTS
Name, Address and Telephone Number	14 VAC 5-211-210 B 1	EOC must contain name, address and telephone number of HMO.
Effective Date and Term of Coverage	14 VAC 5-211-210 B 5	EOC must contain effective date and term of coverage.
Assignment Restrictions	14 VAC 5-211-210 B12	EOC must contain any assignment restrictions in contract.
Claim Filing/Proof of Loss	14 VAC 5-211-210 B13	EOC must contain the plan's claim filing procedures and proof of loss requirements
Incontestability	14 VAC 5-211-210 B15	EOC must have incontestability provision stating that in the absence of fraud, all statements made by subscriber shall be considered representation and not warranties; no statement shall void coverage or deny claims after 2 years from effective date, unless statement was material to the risk.
Entire Contract	14 VAC 5-211-210 B16	EOC must have provision that this contract and any amendment thereto constitute the entire contract and no portion of any other document of the HMO shall be part of contract, unless set forth in EOC.
Grace Period	14 VAC 5-211-210 B17	EOC must have grace period provision of 31 days for payment of any premium falling due after first premium, during which coverage remains in effect, including a statement that if payment is not received within the 31 days, coverage may be cancelled after the 31st day and the terminated members may be held liable for cost of services received during the grace period.
Fraud	§ 38.2-316 D 1	Title 38.2 of the Insurance Code does not define "Insurance Fraud". Any notice regarding insurance fraud is in non-compliance with this section of the Code. Variations in a notice warning of consequences of making fraudulent statements are acceptable. The notice may disclose that it does not apply in Virginia or may disclose states where applicable.
Limiting Liability for Damages	Administrative Letter 1999-5	EOC may not contain provisions which limit HMO's liability in a lawsuit for damages filed by a member which are more restrictive than the guidelines specified in Administrative Letter 1999-5.
Eligibility		
Renewability (Group)	§ 38.2-3432.1	Renewal is at option of the employer, except for 14 reasons listed in this section.
Availability	§ 38.2-3432.2	Coverage must be offered and made available to all eligible employees, as outlined in this section.
Renewability (Individual)	§ 38.2-3514.2	HMO cannot refuse to renew individual plan, except for 5 reasons listed in this section.
Eligibility	14 VAC 5-211-210 B14	EOC must contain plan's eligibility requirements, including the conditions under which dependents may be added, and the limiting age for the dependents and subscriber covered under a group or individual contract.
Preexisting Conditions		
Preexisting Condition Limitation (Group)	§ 38.2-3432.3	Preexisting limits may only be for 6 months for groups and 12 months for individuals (less periods of creditable coverage), as outlined in this section.

REVIEW REQUIREMENTS	REFERENCES	COMMENTS
Preexisting Conditions Provisions and Credit	§ 38.2.3514.1	Individual contracts must contain Pre-existing limitations as outline in this section.
Preexisting Conditions Exclusions	14 VAC 5-211-220	Plan may not limit coverage because of preexisting conditions when enrollee transfers from one HMO plan to another during open enrollment, or when conversion option is elected, except to the extent of the limitation left under the original contract.
Termination		
Termination Notice Employer	§ 38.2-3542 C	Notice must be given to employer at least 15 days prior to terminating contract due to non-payment of premiums.
Reasons for Termination	14 VAC 5-211-230 A	Plan may not terminate member, except for listed reasons: failure to pay premiums or copayments, fraud or deception, violations of terms of contract, failure to meet eligibility requirements. HMO must provide 31-day notice of termination, except for non-payment of premiums and endangering HMO personnel.
Termination Rules	14 VAC 5-211-230 B	EOC must contain terms and conditions under which coverage may be terminated.
Continuation/Conversion		
Right of Conversion	§ 38.2-4306 A 4(g)	Plan must provide for the right of certain group subscribers to convert to individual coverage.
Conversion of Coverage	14 VAC 5-211-70 A	Plan must offer to enrollees the right to convert coverage, within 31 days of termination, to individual coverage which must at a minimum provide basic health care services listed in 14 VAC 5-210-90, and shall not be refused because enrollee no longer resides or is employed in the service area.
Extension of Benefits	14 VAC 5-211-130	Plan must offer extension of benefits, upon discontinuance of contract, to members who are totally disabled at discontinuance. Upon payment of premium, coverage shall remain in full force for not less than 180 days, or until such time as a succeeding carrier elects to provide coverage without limitation as to the disabling condition, or until member is no longer totally disabled. Upon termination of extension of benefits, member has right to conversion.
Copayments		
Copayment Amount	14 VAC 5-211-90 A	Copayment must be shown in EOC as a specified dollar amount which cannot exceed 200% of the annual premium, including employer contributions, for that member or family coverage.
Notification of Enrollee	14 VAC 5-211-90 B	Plan shall keep copayment records, shall notify enrollee no later than 30 days after copayment maximum is reached, shall not charge any further copayments that year, and shall promptly refund any excess copayments paid. EOC must clearly state procedures.
Deductible	14 VAC 5-211-100	An enrollee may be required to pay a reasonable annual deductible in accordance with § 38.2-4303 A 8.
Coordination of Benefits		
COB – Plan Definition	14 VAC 5-211-80 A	Coordination may be with group policy, group contract or group health plan, including coverage under government programs, so that no more than 100% of eligible expense is paid. Plan must provide benefit first, then may seek COB.

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COB Provisions	14 VAC 5-211-210 B11	EOC must contain any coordination of benefits provisions.
Notice Requirements		
Notice Policy Information	§ 38.2-305 B	EOC must contain or have notice attached, as stated in this section. HMOs must have additional statement: "We recommend that you familiarize yourself with our grievance procedure, and make use of it before taking any other action."
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.
Bureau of Insurance and 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."
Appeal of Adverse Decision	§ 32.1-137.9 F	EOC shall contain a clear and complete statement of procedures for reconsideration of an adverse decision and the process of appeal of an adverse decision.
Basic Health Care Services		*HMO shall provide the following benefits as a minimum:*
Inpatient Services	14 VAC 5-211-160 A 1	Inpatient hospital and physician services for a minimum of 90 days per contract or calendar year. Inpatient mental and nervous treatment, including drug and alcohol rehabilitation and treatment shall be provided for not less than 30 days per year. Inpatient drug and alcohol REHABILITATION may be subject to a 90-day lifetime limit. Copayment limits and hospital services are stated in this section which should be read and included in any EOC.
Outpatient Services	14 VAC 5-211-160 A 2	Outpatient medical services are services provided in a physicians office, enrollees home or a non-hospital health care facility and includes consultation and referral services, diagnostic services, treatment services, short term rehabilitation services if significant improvement can be made in 90 days, laboratory and x-ray services, and outpatient surgery. Outpatient mental and nervous benefits shall be made available. See section for details.
Laboratory, X-ray and Radiation Therapy	14 VAC 5-211-160 A 3	Diagnostic laboratory and diagnostic and therapeutic radiologic services.
Preventive Health Care	14 VAC 5-211-160 A 4	Preventive health care, including well-child care from birth, eye and ear exams for children age 17 and under, periodic health evaluations and immunizations.
Emergency Services	14 VAC 5-211-160 A 5	In and out-of-area emergency services, including ambulance services available 24 hours a day, 7 days a week.

REVIEW REQUIREMENTS	REFERENCES	COMMENTS
Mental Health & Substance Abuse	14 VAC 5-211-160 A 6	Biologically based mental illness must be covered as defined in § 38.2-3412.1:01. All other mental health and substance abuse services must include inpatient or partial hospitalization for a minimum 20 days for adults; 25 days for child or adolescent; 20 outpatient visits per contract year. Medication management visits must be covered same as physical illness and not be counted as outpatient treatment visit. See section for all details.
Dental Services	14 VAC 5-211-160 A 7	Dental services as a result of accidental injury and for which treatment is requested within 60 days of the accidental injury.
Out of Area Procedures	14 VAC 5-211-180	Out of area benefits, including offering indemnity benefits covering out of area services. EOC must contain description of procedure for obtaining such benefits and any restriction or limitations. If plan requires preapproval of these services, availability of an emergency telephone consultation on a 24-hours a day, 7-days per week basis is required.
Supplemental Services	14 VAC 5-211-170	Supplemental services are any additional health care service plan chooses to provide. Copayment limitations do not apply to these services.
Mandated Benefits or Provisions		
******Denial of Certain Prescription Drugs Prohibited***	§ 38.2-3407.5	EOC 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 the drug has been prescribed, if the drug is recognized as safe and effective treatment of that specific type of cancer in standard reference compendia.
******Prescription Contraceptives***	§ 38.2-3407.5:1	EOC that contains coverage for prescription drugs on an outpatient basis must offer and make available coverage for contraceptive drugs and 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 benefits provided under a closed formulary, there must be a process to allow medically necessary nonformulary prescription drugs if the formulary drugs are determined by the HMO to be inappropriate therapy. Requests must be acted on within one business day of receipt.
Provider Continuation – Active Treatment	§ 38.2-3407.10.F 1	Terminated provider may continue to treat enrollee for 90 days, if enrollee is under active course of treatment with provider, enrollee requests such continuing care, and provider has not been terminated for cause.
Provider Continuation – Pregnancy	§ 38.2-3407.10.F 2	Terminated provider may continue to treat enrollee, who has entered 2nd trimester of pregnancy at the time of provider's termination, except when provider is terminated for cause. Treatment may continue through postpartum care.
Provider Continuation – Terminal Illness	§ 38.2-3407.10.F 3	Terminated provider may continue to treat enrollee who is determined to be terminally ill at the time of provider's termination, except when the provider is terminated for cause. Treatment may continue for duration of enrollee's life for care of terminal illness.

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Preauthorization Personnel	§ 38.2-3407.10.L	Where preauthorization is required for treatment, HMO must have personnel available to provide such authorization when required.
*****Access to Obstetricians-Gynecologists	§ 38.2-3407.11	Notice of coverage for direct access to obstetrician-gynecologist by female enrollees aged 13 and above.
*****Access to Specialists – Standing Referrals	§ 38.2-3407.11:1	Notice that plan permits enrollee a standing referral, as provided in subsection B of this section.
*****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, but having been cancer free for 5 years or more.
Opt. Point of Service Benefit	§ 38.2-3407.12	Plan must offer POS plan in conjunction with HMO plan as an additional benefit.
Claims Paid from Nonpar. Physicians	§ 38.2-3407.13:2	Payment to employee for non-participating provider. Employee is responsible for paying the non-participating provider.
Obstetrical Care – Nondiscriminatory	§ 38.2-3407.16	Plan with obstetrical benefits must provide such benefits with duration limits, deductibles, coinsurance factors, and copayments no less favorable than physical illness generally.
●Orally Administered Cancer Chemotherapy Drugs	§ 38.2-3407.18	Applicable carriers shall provide that the criteria for establishing cost sharing shall be applied consistently within the same plan for cancer chemotherapy drugs administered orally, and administered intravenously or by injection.
*****Coverage for Childhood Immunizations	§ 38.2-3411.3	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 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.
*****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 of this section.
●Mammograms	§ 38.2-3418.1	Coverage for one mammogram to persons age 35 through 39, one mammogram biennially to persons ages 40 through 49 and one mammogram annually to persons age 50 and over.
●Pap Smears/Gynecologic Cytology Screening	§ 38.2-3418.1.2	Coverage for an annual Pap smear and gynecologic cytology screening.

REVIEW REQUIREMENTS	REFERENCES	COMMENTS
*****Bone/Joint Coverage TMJ Procedures	§ 38.2-3418.2	Cannot exclude nor impose limits on diagnostic and surgical 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 and Congenital Bleeding Disorders	§ 38.2-3418.3	Coverage for expenses incurred for purchase of blood products and blood infusion equipment required for supervised home treatment of routine bleeding episodes associated with hemophilia and other congenital bleeding disorders.
*****Reconstructive Breast Surgery	§ 38.2-3418.4	Coverage for reconstructive breast surgery coincident with a mastectomy performed for breast cancer, to establish symmetry between the two breasts.
*****Early Intervention Services	§ 38.2-3418.5	Coverage for early intervention services with limitation of $5000 per member per policy or calendar year. Coverage is for dependents from birth to age 3 for speech and language therapy, occupational therapy, physical therapy and assistive technology services and devices.
*****Minimum Hospital Stay Mastectomy/Lymph Node Dissection Patients	§ 38.2-3418.6	Coverage for minimum inpatient hospital stay of not less than 48 hours for radical or modified mastectomy, and not less than 24 hours for total mastectomy or partial mastectomy with lymph node dissection for treatment of breast cancer.
●PSA Testing and Digital Exams	§ 38.2-3418.7	Coverage for PSA testing and digital rectal examinations for persons age 50 and over and persons age 40 who are at high risk for prostate cancer.
●Colorectal Cancer Screening	§ 38.2-3418.7:1	Coverage for colorectal cancer screening, as specified in subsection B of this section.
*****Clinical Trials for Cancer	§ 38.2-3418.8	Reimbursement for patient costs incurred during participation in clinical trials for treatment studies on cancer.
*****Minimum Hospital Stay for Hysterectomy	§ 38.2-3418.9	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	Coverage for diabetes benefits for equipment, supplies and in-person outpatient self-management training and education, including medical nutrition therapy.
*****Hospice Care	§ 38.2-3418.11	Coverage for hospice services, including palliative and supportive physical, psychological, psychosocial and other health services to individuals with a terminal illness whose prognosis is death within six months, and who elects to receive palliative care instead of curative care.
*****Hospitalization for Anesthesia and Dental Procedures	§ 38.2-3418.12	Plan must 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 and requires a hospital 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 treatment of morbid obesity through gastric bypass surgery or other methods recognized by the National Institutes of Health as effective for long term reversal of morbid obesity.

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***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 the cost for such health care services that are provided 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	§ 38.2-4312.1	If plan has outpatient prescription drug benefits, plan must allow for freedom of choice of pharmacies, if non-participating pharmacies agree in writing to accept reimbursement, including copayment, at the same rates as participating pharmacies.
24 Hour On Call	§ 38.2-4312.3	Plan must provide access to care and access by telephone to a physician or licensed medical professional who can direct or refer the member where there is an immediate, urgent need or medical emergency.

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

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 reviews health maintenance organizations. 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 maintenance organization filing and determined that it is in compliance with the health maintenance organization checklist.

Signed: _____

Name (please print): _____

Company Name: _____

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

E-Mail Address: _____