Review Requirements Checklist
INDIVIDUAL MAJOR MEDICAL AND PREFERRED PROVIDER ORGANIZATION (PPO)
(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.
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.
Company Name and Address	14 VAC 5-100-50 2	Full and proper name (including "Inc.") must appear prominently on first page or cover sheet of all forms.
Final Form	14 VAC 5-100-50 3	Form must be submitted in "final form" and in "John Doe fashion" to indicate its intended use.
Application	14 VAC 5-100-50 4	Any policy form which is to be issued with an attached application, must be filed with a copy of the application completed in "John Doe" fashion to indicate its intended use. (If an application was previously approved, advise date of approval.)
Type Size	14 VAC 5-100-50 5	Individual Accident and Sickness forms must be printed with type size of at least ten-point.
Arbitration	§ 38.2-312	Contract may not deprive courts of Virginia jurisdiction in actions against insurer. Arbitration may not be binding.
Fraud Notice	§ 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.
Form of Policy		
Money/Consideration	§ 38.2-3500 A 1	The entire consideration must be expressed in the policy.
Effective-Terminates	§ 38.2-3500 A 2	The clock time at which the policy becomes effective and terminates must be expressed in the policy.

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Form Number	§ 38.2-3500 A 5	Each form, including riders and endorsements, is identified by a form number in the lower left-hand corner of the first page of the form.
Payor of Last Resort	§ 38.2-3500 A 7	Policy must contain a statement regarding the status of the Department of Medical Assistance Services as the payor of last resort.
Definition of eligible family members	§ 38.2-3500 C	The definition establishes that eligible dependent children may not be required to live in the household as the policyowner.
Notice and Return of Policy	§ 38.2-3502 A	Each policy must display on the first page the specified caution notice and 10-day free look provision.
Policies that include issue ages of 65 or higher	14 VAC 5-170-150 E 1	Any policy marketed to persons age 65 or older must contain a notice that discloses that the policy is not a Medicare supplement policy or certificate.
Required Policy Provisions		
Contents of Policy	§ 38.2-305 A	Parties to policy named; subject of insurance; risks insured against; time insurance takes effect; statement of the premium.
Entire Contract; Changes	§ 38.2-3503 1	The policy, including endorsements and attached papers constitutes the entire contract of insurance. No change in the policy is valid until approved by an executive officer of the company, and such approval endorsed on or attached to the policy. No agent has authority to change or waive policy provisions.
Time Limit on Certain Defenses	§ 38.2-3503 2	After 2 years from the date of the policy, only fraudulent misstatements in the application may be used to void the policy or deny a claim.
Incontestable (optional)	§ 38.2-3503 2 a	After 2 years from issue during the insured's lifetime, the company cannot contest statements in the application.
Preexisting Conditions	§ 38.2-3503 2 b	No claim for loss incurred or disability that starts after 1 year from the date of issue of the policy will be reduced or denied because a sickness or physical condition existed before the effective date of coverage (unless excluded by name or specific description before the date of loss).
Grace Period	§ 38.2-3503 3	If a renewal premium is not paid on time, it may be paid during the following 31 days. During the 31 days the policy shall continue in force. Please review entire statute for variations.
Reinstatement	§ 38.2-3503 4	If a renewal premium is not received within the grace period, the policy will lapse, and the individual may apply for reinstatement based on the company's guidelines. The reinstated policy will cover only loss that results from injury sustained after the reinstatement date and sickness that starts more than 10 days after such date.

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Notice of Claim	§ 38.2-3503 5	Written notice of claim must be given to the company within 20 days after covered loss starts or as soon as reasonably possible, and should include the name of the insured or claimant, and policy number. The location should be indicated for sending notice to the company.
Claim Forms	§ 38.2-3503 6	The company must provide the claimant with claim forms within 15 days of notification of a claim. If not, proof of loss is met by giving the company a written statement of the nature and extent of the loss within the time limit expressed in the proofs of loss provision.
Proofs of Loss	§ 38.2-3503 7	For periodic payment, written proof of loss must be given to the company within 90 days after the end of each period for which the company is liable. For any other loss, proof must be given within 90 days of the loss. If not reasonably possible to give proof in the time provided, the company shall not reduce or deny a claim if proof is filed as soon as reasonably possible. In any event, except in the absence of legal capacity, proof must be given no later than 1 year from the time specified.
Time of Payment of Claim	§ 38.2-3503 8	After the company receives written proof of loss, it shall pay benefits according to a specified frequency for a specified loss. Benefits for any other loss will be paid as soon as written proof is received.
Payment of Claims	§ 38.2-3503 9	Benefits will be paid to the insured if living, otherwise to the beneficiary or the insured's estate. In the absence of a valid release, the company may pay up to $2000 to someone whom the company deems entitled.
Physical Exams & Autopsy	§ 38.2-3503 10	The company, at its own expense, may have the insured examined as often as reasonably necessary while a claim is pending. An autopsy may also be made unless prohibited by law.
Legal Actions	§ 38.2-3503 11	No legal action may be brought to recover on the policy within 60 days after written proof of loss has been given. No legal action may be brought after 3 years from the time written proof of loss is required to be given.
Change of Beneficiary	§ 38.2-3503 12	The insured may change the beneficiary at any time, but the beneficiary's consent is required in the case of an irrevocable beneficiary designation.
Cancellation by Insured	§ 38.2-3503 13	The insured may cancel this policy at any time by written notice to the company. In the event of cancellation, the company shall promptly return the unearned portion of any premium; the earned premium shall be computed pro rata. Cancellation shall be without prejudice to any claim originating prior to the effective date of cancellation.
Other Provisions		
Change of Occupation	§ 38.2-3504 1	This provision sets forth the recourse in the event the insured is injured or contracts sickness after having changed his occupation to one classified by the company as more hazardous than that stated in the policy, and for when an occupation is considered by the company to be less hazardous.

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Misstatement of Age	§ 38.2-3504 2	If the insured's age has been misstated, the benefits will be those the premium paid would have purchased at the correct age.
Other Insurance with Insurer	§38.2-3504 3	If the insured has more than 1 policy with the insurer, the insured may keep the 1 policy he, his beneficiary or his estate has elected, and the company will return all premiums paid for all other such policies. Please review this statute for variations.
Unpaid Premium	§ 38.2-3504 7	When a claim is paid, any premium due and unpaid may be deducted from the claim payment.
Conformity with State Statutes	§ 38.2-3504 9	Any provision of the policy that on its effective date is in conflict with the laws of the state in which the insured resides on that date is amended to conform to the minimum requirements of the laws.
Illegal Occupation	§ 38.2-3504 10	The company is not liable for any loss that results from the insured committing or attempting to commit a felony or engaging in an illegal occupation.
Intoxicants and Narcotics	§ 38.2-3504 11	The company is not liable for any loss resulting from the insured being drunk, or under the influence of any narcotic unless taken on the advice of a physician.
Definitions	14 VAC 5-140-40	General terms defined in connection with individual accident and sickness coverage.
Continuation of coverage for spouse/deceased insured	14 VAC 5-140-50 A	For guaranteed renewable and noncancellable policies, the spouse of the insured will become the insured in the event of the insured's death.
Age and duration requirements	14 VAC 5-140-50 C	For guaranteed renewable and noncancellable policies, the age of the younger spouse must be used as the basis for meeting the age and durational requirements of the renewability definitions.
Military refund	14 VAC 5-140-50 E	If a policy includes a status type military exclusion, the insurer will provide for refund of the premium, on a pro rata basis, upon receipt of a written notice of military service.
Prohibited Policy Provisions	14 VAC 5-140-60	Specified provisions that are not allowed in a policy.
Probationary period prohibited	14 VAC 5-140-60 A	Probationary periods are prohibited for all medical conditions except a policy may specify a probationary period not to exceed six months for certain conditions.
Authorized exclusions	14 VAC 5-140-60 F	Permitted exclusions and limitations.
Required Disclosure Provisions	14 VAC 5-140-80	Rules for all policies and limited benefit policies.
Preexisting condition	14 VAC 5-140-80 A 5	If a policy contains a preexisting condition limitation, the limitations must appear in a separate paragraph and labeled as "Preexisting Conditions Limitations."
Reduction of benefits due to age	14 VAC 5-140-80 A 6	If age is used as a determining factor for reducing the maximum aggregate benefits made available in the policy as originally issued, such fact must be disclosed prominently in the policy.
Rate Filing	14 VAC 5-130-60	Rate schedule and certified actuarial memorandum for coverage.

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Readability Certification	14 VAC 5-110-60	Disclose the score, number of words, sentences, and syllables for each form.
General Provisions		
Contents of Policy	§ 38.2-305 A	Parties to policy named; subject of insurance; risks insured against; time insurance takes effect; statement of the premium.
Unfair Discrimination	§ 38.2-508	No person can unfairly discriminate between individuals of the same class or essentially the same hazard with regard to benefits, coverage, eligibility, rates, policy provisions, or termination of insurance.
Medicaid Eligibility	§ 38.2-508.3	When considering eligibility for insurability for coverage and determining benefits, Medicaid eligibility/status 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.
Coordination of Benefits with Liability Coverage Prohibited	§ 38.2-3405 B	Benefits provided under liability insurance cannot operate to reduce benefits under policy.
Worker's Compensation Exclusion	§ 38.2-3405 C	Benefits payable under worker's compensation may be excluded from coverage, but medical condition pursuant to exclusion may not. May be variations.
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 and maintenance. Additional premium may be charged based upon class of risks.
Newborn Children Coverage	§ 38.2-3411	For family coverage, newborn children covered from moment of birth for first 31 days; policy specifies terms for extended coverage. Coverage includes medically diagnosed congenital defects and birth abnormalities, treatment for cleft lip, cleft palate or ectodermal dysplasia.
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.
Minimum Standards		***Major Medical Expense and Preferred Provider Organization Coverage***
	14 VAC 5-140-70 E	Basic coverage for hospital, medical and surgical expense coverage to the extent of: (a) An aggregate maximum of not less than $25,000.
Copayment		(b) By covered person not to exceed 25% of covered charges.
Deductible		(c) Not to exceed 5% of the aggregate maximum limit under the policy stated on basis per person, per family, per illness, per benefit period, per year, or a combination of such bases.
Prior to application of the Copayment percentage, at least the following:	Subsection 1	Daily hospital room and board expenses for not less than $100 daily (or the average daily cost of the semi-private room rate in the area where the insured resides) for a period of not less than 60 days of hospital confinement.

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	Subsection 2	Miscellaneous hospital services for an aggregate maximum of not less than $3,000 or 15 times the specified dollar amount for the daily room and board rate.
	Subsection 3	Surgical services of not less than $1,200 for the most severe operation with the amounts provided for other operations reasonably related to such maximum amount.
	Subsection 4	Anesthesia services for a maximum of not less than 15% of covered surgical fees or, if the surgical schedule is based on relative values, not less than the amount provided for anesthesia services at the same unit value used for the surgical schedule.
	Subsection 5	In-hospital medical services consisting of physician services rendered to a person who is a bed patient in a hospital for treatment of sickness or injury other than for surgical care .
	Subsection 6	Out-of-hospital care consisting of physicians' services rendered on an ambulatory basis where coverage is not provided elsewhere in the policy for diagnosis and treatment of sickness or injury, diagnostic x-ray, laboratory services, radiation therapy, and hemodialysis ordered by a physician.
	Subsection 7	Not fewer than 3 of the following additional benefits, or an aggregate maximum of such covered charges of not less than $2,000: (a) In-hospital private duty graduate registered nurse services (b) Convalescent nursing home care (c) Diagnosis and treatment by a radiologist or physiotherapist (d) Rental of special equipment, as defined in the policy, (e) Artificial limbs or eyes, casts, splints, trusses or braces, (f) Out-of hospital prescription drugs and medications.
Availability	§ 38.2-3430.3	Coverage must be offered and made available to Eligible Individuals.
Special Rules for Network Plans	§ 38.2-3430.4	Limitations related to service areas.
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.
Pre-Existing Conditions		
Pre-Existing Condition	§ 38.2-3432.3 A 2 & 3	Pre-existing conditions limitation can only be for 12 months (less periods of creditable coverage).
Pre-X; Credit/1 year	§ 38.2.3514.1	Pre-existing conditions limitation provision is for 12 months, and has 12-month look back period.
Notice requirements		
Important Information Regarding Your Insurance	§ 38.2-305 B	Virginia requires a specific notice to accompany each new or renewal insurance policy, contract, certificate or evidence of coverage.

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Policies that include issue ages of 65 or higher	14 VAC 5-170-150 E 1	Any policy marketed to persons age 65 or older must contain a notice that discloses that the policy is not a Medicare supplement policy or certificate.
Service Area(s)	§ 38.2-5803 A 2	Description of the service area or areas within which the MCHIP shall provide health care services.
Ombudsman Notice	§ 38.2-5803 A 5	Disclosure made available at least annually in prominent notice in the evidence of coverage 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.
BOI and DOH Notice	§ 38.2-5803 A 4	Notice made available that the MCHIP is subject to regulation in this Commonwealth by the State Corporation Commission Bureau of Insurance pursuant to Title 38.2 and the Virginia Department of Health pursuant to Title 32.1."
Adverse Decision Appeal	§ 32.1-137.9 F	Policy shall contain a clear and complete statement of procedures for reconsideration of an adverse decision and the process of appeal from an adverse decision.
Mandated Benefits or Provisions		
Denial of Benefits for Certain Prescription Drugs Prohibited	§ 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.
Prescription Contraceptives	§ 38.2-3407.5:1	Policy that contains coverage for prescription drugs on an outpatient basis must offer and make available coverage for prescription contraceptive drugs and devices.
Denial of Benefits for Certain Prescription Drugs Prohibited	§ 38.2-3407.6:1	Policy 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.
Pharmacy Freedom Choice	§ 38.2-3407.7	If policy includes prescription drug benefits, must allow for freedom of choice of pharmacies, to include nonpreferred providers who have agreed in writing to accept reimbursement at the same rates as preferred providers, including copayment imposed by the insurer.
Prescription Drug Formularies	§ 38.2-3407.9:01 B	For policies using closed formularies, must have a process to allow medically necessary nonformulary prescription drug if the formulary drug is determined by the insurer to be inappropriate therapy. Requests must be acted on within one business day of receipt. Additional requirements apply to participating and nonparticipating providers and pharmacists.

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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 Obstetrician-Gynecologists	§ 38.2-3407.11	Policy that includes coverage for obstetrical or gynecological services shall allow an annual examination and health services for a female age 13 years or older with a participating provider of such services, without need for prior authorization.
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	Prohibits insurers 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.
Obstetrical Care – Nondiscriminatory	§ 38.2-3407.16	Policy with obstetrical benefits must provide for postpartum services such benefits with duration limits, deductibles, coinsurance factors, & copayments no less favorable than physical illness generally.
Child Health Supervision Services	§ 38.2-3411.1	Offer and make available coverage for periodic review of a child's physical and emotional status, to include history, physical examination, developmental assessment, anticipatory guidance, immunizations, and laboratory tests. Reviews are scheduled at interval ages from birth to age 6. See entire statute for exceptions.
Childhood Immunizations	§ 38.2-3411.3	Routine and necessary immunizations against diphtheria, pertussis, tetanus, polio, hepatitis B, measles, mumps, rubella, and other such immunizations prescribed by the Commissioner of Health. Coverage applies to children from birth to 36 months of age. Does not apply if insured elects child health supervision services.
Coverage for Infant Hearing Screening and Audiological Examinations	§ 38.2-3411.4	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 a physician or audiologist and performed by a licensed audiologist to confirm the existence or absence of hearing loss.
Mental Health and Substance Abuse	§ 38.2-3412.1 A	Defined terms associated with coverage for mental health and substance abuse services.
Adult Inpatient Treatment	§ 38.2-3412.1 B 1	Coverage for minimum of 20 days per policy or contract year.
Child Inpatient Treatment	§ 38.2-3412.1 B 2	Coverage for minimum of 25 days per policy or contract year.
Partial Hospitalization	§ 38.2-3412.1 B 3	Up to 10 days of inpatient benefit may be accumulated at an exchange of 1.5 days of partial hospitalization for each inpatient day of coverage.

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Outpatient Treatment	§ 38.2-3412.1 C	Minimum of 20 visits for outpatient treatment of an adult, child, or adolescent shall be provided with limits on benefits no less restrictive than limits on benefits applicable to physical illness. Coinsurance factors beyond the first 5 visits shall be at least 50%.
Obstetrical Benefits – Coverage for Postpartum Services	§ 38.2-3414.1	Policy providing benefits for obstetrical services must have coverage for postpartum services as provided in subsection B of this statute.
Victims of Rape or Incest	§ 38.2-3418	Policy shall be construed to include benefits for pregnancy following rape or incest of female under 13 years of age if policy provides benefits as a result of an accident/accidental injury.
Mammograms	§ 38.2-3418.1	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	Coverage for an annual Pap smear & gynecologic cytology screening technologies.
Bone/Joint Coverage, TMJ Procedures	§ 38.2-3418.2	Cannot exclude nor impose limits for 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 of the skeletal structure.
Hemophilia & 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 insured or 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 stays for radical or modified mastectomy of not less than 48 hours and not less than 24 hours for total mastectomy or partial mastectomy with lymph node dissection for treatment of breast cancer.
PSA Testing & Digital Rectal Exams	§ 38.2-3418.7	Coverage for PSA testing and digital rectal examinations for persons age 50 and over, and persons age 40 and over 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 statute.
Clinical Trials for Treatment Studies on Cancer	§ 38.2-3418.8	Reimbursement for patient costs incurred during participation in clinical trials for treatment studies on cancer.

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Minimum Hospital Stay for Hysterectomy	§ 38.2-3418.9	Coverage for minimum hospital stay of not less than 23 hours for a laproscopy-assisted vaginal hysterectomy and 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 & Dental Procedures	§ 38.2-3418.12	Coverage 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 surgery facility to effectively and safely provide dental care for persons (1) under age 5, or (2) severely disabled, or (3) has a medical condition requires a hospital or outpatient surgery facility and general anesthesia for dental care 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 Institutes of Health as effective for long term reversal of morbid obesity.
Coverage for Lymphedema	§ 38.2-3418.14	Equipment, supplies, complex decongested therapy, outpatient self-management training and education.
Coverage for Prosthetic Devices and Components	§ 38.2-3418.15	Medically necessary prosthetic devices, their fitting, repair and replacement: components, limbs, devices.
Coverage for Telemedicine Services	§ 38.2-3418.16	Interactive studio, video, or other electronic media used for the purpose of diagnosis, consultation, or treatment.
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.

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 individual major medical and preferred provider organizations (PPOs). 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 individual major medical and preferred provider organization (PPO) filing and determined that it is in compliance with the individual major medical and preferred provider organization (PPO) checklist.

Signed: _____

Name (please print): _____

Company Name: _____

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

E-Mail Address: _____