Notice: This document is intended to assist carriers in preparing form and rate filings for Short-term Limited-duration (STLD) Health Maintenance Organizations (HMOs) marketed to association groups, for review by the Bureau of Insurance. It provides guidance based on current Virginia laws and regulations in addition to pending legislation.

Short-term Limited-duration insurance coverage means health insurance coverage that has an expiration date specified in the contract that is less than 12 months after the original effective date in the contract and, taking into account renewals or extensions, has a duration of no longer than 36 months in total (45 CFR § 144.103).

Required Disclosures	***Federal and/or Virginia Citation***	***Comments***	
Disclosure (Use this disclosure if the policy is effective on or after 1/1/2019) **Prominently in the contract and in any application materials;** **At least 14-point type;** **Sentence case.**	**45 CFR § 144.103**	This coverage is not required to comply with certain federal market requirements for health insurance, principally those contained in the Affordable Care Act. Be sure to check your policy carefully to make sure you are aware of any exclusions or limitations regarding coverage of preexisting conditions or health benefits (such as hospitalization, emergency services, maternity care, preventive care, prescription drugs, and mental health and substance use disorder services). Your policy might also have lifetime and/or annual dollar limits on health benefits. If this coverage expires or you lose eligibility for this coverage, you might have to wait until an open enrollment period to get other health insurance coverage.	

Review Requirements	Federal and/or Virginia Citation	Comments	Page No.
Out-of-State Filing Requirements			
Out-of-State Guidelines		Companies will need to notify Virginia of: 1. The state in which the policy will be issued; and 2. Whether the policy will be issued to a defined or a non-defined group. See list of defined groups under § 38.2-3521.1. This will determine what type of review will need to be made.	
Out-of-State Defined Groups	§ 38.2-3522.1 B 1	Companies submitting a policy that is issued in another state that has similar laws as Virginia and have made a determination that such requirements have been met are required to file a certification which is signed by an officer of the company having the responsibility for forms compliance. This certification will need to certify that all group insurance coverage marketed to residents of the Commonwealth of Virginia under policies which have not been approved by this Commonwealth will comply with § 38.2-3521.1 or have met the requirements set forth in A 1 thru A 3 of § 38.2-3522.1.	
Out-of-State Non-Defined Groups	§ 38.2-3522.1 B 2	Companies submitting forms that are unable to provide documentation under subdivision 1 above shall be required to file forms consistent with § 38.2-316 of the Code of Virginia. The forms shall be required to be approved as meeting all of the requirements of this title to the forms being offered to residents in Virginia.	
Policies Issued Outside of Virginia	§ 38.2-3523.2	Any group policy issued outside of Virginia that provides coverage for residents in Virginia that do not qualify under § 38.2-3521.1 or § 38.2-3522.1 shall be subject to the requirements of this title and may subject the insurer to penalties available under this title of such requirements.	
General Filing Requirements			
	14VAC5-100-40 1	Forms must have a number that consists of digits, letters or a combination of both.	
	14VAC5-100-40 3	Certificate of Compliance signed by General Counsel or officer of company, or attorney or actuary representing company is required.	
	14VAC5-100-40 5	Description of market for which the forms are intended.	
Form Number	14VAC5-100-50 1 § 38.2-3500 A 5	Form number must appear in lower left-hand corner of **first page** of each form.	
Company Name & Address	14VAC5-100-50 2	Full and proper corporate name (including "Inc.") and address must prominently appear on **cover sheet** of all policies and other forms.	
Final form	14VAC5-100-50 3	Form must be submitted in the form in which it will be issued and completed in "John Doe" fashion to indicate its intended use.	

Review Requirements	Federal and/or Virginia Citation	Comments	Page No.
Application	14VAC5-100-50 4	Any form, which is to be issued with an attached application must be filed with a copy of the application completed in "John Doe" fashion to indicate its intended use. (If an application was previously approved, advise date of approval.)	
Type Size	14VAC5-100-50 5	Forms must be printed with a type size of at least eight-point.	
Variable Language	SERFF – Virginia General Instructions	All variable information must be bracketed and explained in detail. A Statement of Variability (SOV) should be provided in all cases where variable information is presented. The SOV should be detailed and specific. It should identify each variable field appearing in the forms and describe specifically how that field will vary from the text as presented. For any variable numerical information, please express the minimum and maximum values. Any variable language must be defined sufficiently so that compliance with statutory or regulatory requirements can be determined. The SOV should be provided under Supporting Documentation.	
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.***	
General Information – Filing Description		(i) Description of each form by name, title, edition date, and intended use.	
		(ii) Identification of changes in benefits and premiums (previously approved or filed forms). [Place changed contract provisions (red-lined or highlighted) in Supporting Documentation].	
		(iii) Identification of SERFF or state tracking number for the previously approved or filed form for which the new form revises, replaces, or is intended to be used.	
		(iv) A statement as to whether any other regulatory body has withdrawn approval of the form because the form contains one or more provisions that were deemed to be misleading, deceptive or contrary to public policy.	
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.	

Review Requirements	Federal and/or Virginia Citation	Comments	Page No.
		Pursuant to Administrative Letter 1998-11, any change that increases or decreases, or is likely to increase or decrease a health carrier's revenues, expenses, or net worth in an amount that exceeds 5% of the health carrier's current net worth qualifies as a material change that must receive prior approval from the Financial Regulation Division. 3. A response as to whether or not the Virginia Department of Health (VDH) has determined that the network is adequate.	
Provider Lists	§ 38.2-5803 A 1	Plan must provide a list of the names and locations of all affiliated providers. Such list may be made available in a form other than a printed document, provided the purchaser or existing enrollee is given the means to request and to receive a printed copy of such list.	
Service Area	§ 38.2-5803 A 2	Description of service area or areas shall be described in the policy/Evidence of Coverage (EOC).	
Complaints	§ 38.2-5803 A 3	Description of method of resolving complaints. **Provide most recent approval date of Complaints and Appeals process from the Bureau of Insurance and Virginia Department of Health. Please attach copies of approvals under Supporting Documentation. Is the language in the submitted forms identical in substance to the approved language?**	
Bureau of Insurance & Department of Health Notice	§ 38.2-5803 A 4	Each EOC shall contain a notice: "This Company is subject to regulation in this Commonwealth by the State Corporation Commission Bureau of Insurance pursuant to Title 38.2 and by the Virginia Department of Health pursuant to Title 32.1".	
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 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.	
MCHIP Complaint System and Appeals Procedures	14VAC 5-216-10, et al.	Please see separate MCHIP Complaint System Filing/Appeal Procedures Checklist at: http://www.scc.virginia.gov/boi/co/index.aspx	
External Review Requirements			
Disclosure Requirements	§ 38.2-3570 14VAC5-216-20	Each carrier shall include a description of the external review procedures in or attached to the policy, certificate or evidence of coverage. See statute for requirements.	
General Provisions			
Continuation of Coverage	14VAC5-211-70 A	Each EOC shall contain a provision that provides for continuation of coverage.	
Cost Sharing	14VAC5-211-90 A	Copayment must be shown in EOC as specified dollar or as a coinsurance, but not both.	

Review Requirements	Federal and/or Virginia Citation	Comments	Page No.
Cost Sharing Notification	14VAC5-211-90 B	Plan shall keep cost sharing records, shall notify enrollee no later than 30 days after out-of-pocket maximum or cost sharing is reached, shall not charge any further cost sharing that year, and shall promptly refund any excess cost sharing paid. EOC must clearly state procedures.	
Extension of Benefits	14VAC5-211-130	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.	
Name, Address and Telephone Number	14VAC5-211-210 B 1	EOC must contain name, address and telephone number of HMO.	
Effective Date and Term of Coverage	14VAC5-211-210 B 5	EOC must contain effective date and term of coverage.	
Arbitration	14VAC5-211-210 B 7	A description of the HMO's method of resolving enrollee complaints, including a description of any arbitration procedure if complaints may be resolved through a specified arbitration agreement.	
COB Provisions	14VAC5-211-210 B 11	EOC must contain any coordination of benefits provisions.	
Assignment Restrictions	14VAC5-211-210 B 12	EOC must contain any assignment of benefit restrictions in contract.	
Claim Filing/Proof of Loss	14VAC5-211-210 B 13	EOC must contain the plan's claim filing procedures and proof of loss requirements.	
Eligibility Requirements	14VAC5-211-210 B 14	Conditions under which dependents may be added.	
Entire Contract	14VAC5-211-210 B 15	EOC shall contain a provision that the contract or evidence of coverage and any amendments to it constitutes the entire contractual agreement between the parties involved and that no portion of the charter, bylaws, or other document of the health maintenance organization shall constitute part of the contract unless it is set forth in full in the contract.	
Grace Period	14VAC5-211-210 B 16	EOC shall contain a provision that the policyholder/member is entitled to a grace period of not less than 31 days for the payment of any premium due, except for the first premium. During the grace period, the coverage shall continue in force.	
Reasons for Termination	14VAC5-211-230 A	Plan may not terminate member, except for the listed reasons: failure to pay premiums, fraud or intentional misrepresentation of material fact, discontinuance of group, or failure to meet eligibility requirements.	
Termination Rules	14VAC5-211-230 B	EOC must contain terms and conditions under which coverage may be terminated. HMO Must provide 31-day notice of termination, except for non-payment of premiums and change in eligibility status.	

Review Requirements	Federal and/or Virginia Citation	Comments	Page No.
Rescission	14VAC5-211-230 C	An HMO shall not rescind coverage unless the enrollee performs an act, practice, or omission that constitutes fraud, or the person makes an intentional misrepresentation of material fact, as prohibited by the terms of the plan.	
Contents of Policies	§ 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. (6) 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, health maintenance organizations, health services plans, credit 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.	
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.	
Subrogation	§ 38.2-3405 A	Plan 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 14VAC5-211 80 A	No plan shall require the 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 Exclusion	§ 38.2-3405 D	Except for specified circumstances, issuers shall not exclude coverage for any medical condition whenever benefits payable under workers' compensation are excluded from coverage.	
Calculation of Cost-Sharing Provisions	§ 38.2-3407.3	Coinsurance the member is required to pay must be based upon the amount actually paid or payable to the provider. Statements in EOC or Schedules that refunds, rebates and post-payment adjustments will not be considered in the calculation of coinsurance are prohibited.	

Review Requirements	Federal and/or Virginia Citation	Comments	Page No.
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 USFDA to treat: (i) Cancer because the drug has not been approved by 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. **Does not apply to short-term nonrenewable policies of not more than 6 months' duration.**	
Prescription Contraceptives	§ 38.2-3407.5:1	Plan that contains coverage for prescription drugs must offer coverage for prescribed contraceptive drugs & devices approved by the USFDA. **Does not apply to short-term nonrenewable policies of not more than 6 months' duration.**	
Hormonal Contraceptives	§ 38.2-3407.5:2	A plan covering hormonal contraceptives shall cover up to a 12-month supply when dispensed or furnished at one time. **Does not apply to short term nonrenewable polices of not more than 6 months' duration.**	
Denial of Benefits for Certain Prescription Drugs Prohibited	§ 38.2-3407.6:1	Each 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 the recommended dosage, if prescribed for a patient with intractable cancer pain. **Does not apply to short-term nonrenewable policies of not more than 6 months' duration.**	
Ambulance Services	§ 38.2-3407.9	Policies covering ambulance services must provide that the ambulance provider will receive reimbursement from the health carrier when there is an assignment of benefits. A covered person must not be required to obtain prior authorization for ambulance services and must not be directed to use any system other than an emergency 911 system or other state, county or municipal emergency medical system for ambulance services.	
Prescription Drug Formularies	§ 38.2-3407.9:01 B 1, 2, 3	For plans using closed formularies, plan must have a process to allow a medically necessary nonformulary prescription drug if the formulary drug is determined by the HMO 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 USFDA approval.	

Review Requirements	Federal and/or Virginia Citation	Comments	Page No.
Partial Supply of Prescription Drugs	§ 38.2-3407.9:04 B	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. Such proration may not occur more frequently than annually.	
Provider Continuation – Active Treatment	§ 38.2-3407.10 F 1	Terminated provider may continue to treat enrollee for at least 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.	
Preauthorization Personnel	§ 38.2-3407.10 L	Where preauthorization is required for treatment, the HMO must have personnel available to provide such authorization when required.	
Reduction of Benefits	§ 38.2-3407.10 M	Carriers shall provide group policyholders written notice of any benefit reductions. Policyholders shall provide enrollees written notice of benefit reductions.	
Access to Obstetrician-Gynecologists	§ 38.2-3407.11	Policy shall allow direct access to an obstetrician-gynecologist for 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. **Does not apply to short-term nonrenewable policies of not more than 6 months' duration.**	
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 section. **Does not apply to short-term nonrenewable policies of not more than 6 months' duration.**	
Standing Referrals 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 standing referral to board-certified physician in pain management or oncologist authorized to provide services. **Does not apply to short-term nonrenewable policies of not more than 6 months' duration.**	
Breast Cancer Preexisting Condition Restrictions	§ 38.2-3407.11:3	Coverage must not deny the renewal of, cancel, or exclude benefits because of certain breast cancer factors or due to previous breast cancer if the individual has been breast cancer free for five years or more. Benefits must be provided with durational limits and cost-sharing no less favorable than for physical illness generally. **Does not apply to short-term nonrenewable policies of not more than 6 months' duration.**	

Review Requirements	Federal and/or Virginia Citation	Comments	Page No.
Coordination of Benefits: Notice of Primary Coverage	§ 38.2-3407.13:1	COB provision shall be prominent in enrollment materials.	
Claims Paid to Enrollees for Services from Nonpar. Physicians	§ 38.2-3407.13:2	When an HMO follows a policy of sending payment to enrollee, the certificate and explanation of benefits must include notice for the enrollees, for services performed by a nonparticipating provider, informing the enrollee of his or her responsibility to apply the plan payment to the claim from such nonparticipating provider.	
Proton Radiation Therapy Decisions	§ 38.2-3407.14:1	Each policy or contract that provides coverage for cancer therapy shall not hold proton radiation therapy to a higher standard of clinical evidence than for decisions regarding coverage of other types of radiation therapy treatment.	
Obstetrical Care	§ 38.2-3407.16	Obstetrical service benefits shall be no less favorable than a physical illness generally.	
Orally Administered Cancer Chemotherapy Drugs	§ 38.2-3407.18	Carriers shall include coverage for cancer chemotherapy drugs administered orally and intravenously or by injection and shall provide that the durational limits, deductibles, coinsurance factors and copayments 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.	
Newborn Children	§ 38.2-3411	Plan shall provide newborn coverage from the moment of birth. Coverage must be the same as for the member including congenital defects and birth abnormalities. Must notify HMO within 31 days of birth for coverage to continue.	
Adopted Children	§ 38.2-3411.2	Any benefits applicable for children under the plan shall be payable with respect to adopted children from the date of adoptive or parental placement with member for the purpose of adoption.	
Childhood Immunizations	§ 38.2-3411.3	Coverage shall include 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 to short-term nonrenewable policies of not more than 6 months' duration.**	
Coverage for Infant Hearing Screening and Audiological Examinations	§ 38.2-3411.4	Coverage shall include infant hearing screenings and all necessary audiological examinations pursuant to § 32.1-64.1, using technology approved by the USFDA and, as recommended by a physician or audiologist and performed by a licensed audiologist to confirm the existence or absence of hearing loss. **Does not apply to short-term nonrenewable policies of not more than 6 months' duration.**	

Review Requirements	Federal and/or Virginia Citation	Comments	Page No.
Postpartum Services	§ 38.2-3414.1	Plan must provide coverage for postpartum services as provided in subsection B of this statute.	
Mammograms	§ 38.2-3418.1	Coverage shall be included for one mammogram to persons age 35 through 39, one mammogram biennially to persons age 40 through 49 and one mammogram annually to persons age 50 and over. **Does not apply to short-term nonrenewable policies of not more than 6 months' duration.**	
Pap Smears/Gynecological Cytology Screening	§ 38.2-3418.1:2	Coverage shall be included for an annual pap smear and gynecologic cytology screening technologies. **Does not apply to short-term nonrenewable policies of not more than 6 months' duration.**	
Bones/Joints	§ 38.2-3418.2 A	Plan shall not exclude or impose limits on treatment involving any bone or joint of the head, neck, face, or jaw which are more restrictive than limits applicable to other bones or joints of the skeletal structure based on certain conditions. **Does not apply to short-term nonrenewable policies of not more than 6 months' duration.**	
Hemophilia & Congenital Bleeding Disorders	§ 38.2-3418.3 C	Plan shall provide coverage for hemophilia and congenital bleeding disorders. Benefits must include treatment of routine bleeding episodes, purchase of blood products and blood infusion equipment for home treatment. **Does not apply to short-term nonrenewable policies of not more than 6 months' duration.**	
Reconstructive Breast Surgery	§ 38.2-3418.4	Plan shall provide coverage for reconstructive breast surgery as outlined in this section coincident with or following a mastectomy, or following a mastectomy to reestablish symmetry between the two breasts. **Does not apply to short-term nonrenewable policies of not more than 6 months' duration.**	
Early Intervention Services	§ 38.2-3418.5	Each plan shall provide coverage for medically necessary early intervention services which includes speech and language therapy, occupational therapy, physical therapy and assistive technology services and devices for certain dependents. **Does not apply to short-term nonrenewable policies of not more than 6 months' duration.**	

Review Requirements	Federal and/or Virginia Citation	Comments	Page No.
Minimum Hospital Stay Mastectomy/Lymph Node Dissection Patients	§ 38.2-3418.6	Coverage shall be provided for a minimum inpatient hospital stay of not less than 48 hours following a radical or modified mastectomy and not less than 24 hours of inpatient care following a total mastectomy or partial mastectomy with lymph node dissection for the treatment of breast cancer. **Does not apply to short-term nonrenewable policies of not more than 6 months' duration.**	
PSA Testing & Digital Rectal Exams	§ 38.2-3418.7	Coverage shall be provided for one PSA test in a 12-month period and digital rectal examinations for persons age 50 and over or age 40 if at high risk for prostate cancer. **Does not apply to short-term nonrenewable policies of not more than 6 months' duration.**	
Colorectal Cancer Screening	§ 38.2-3418.7:1	Each plan shall provide coverage for colorectal cancer screening, specifically screening with an annual fecal occult blood test, flexible sigmoidoscopy or colonoscopy, or in appropriate circumstances, radiologic imaging. **Does not apply to short-term nonrenewable policies of not more than 6 months' duration.**	
Clinical Trials for Treatment Studies on Cancer	§ 38.2-3418.8	Each plan shall provide coverage for participation in an approved clinical trial for treatment studies on cancer and cover routine patients costs for items and services in connection with a participation in the trial. **Does not apply to short-term nonrenewable policies of not more than 6 months' duration.**	
Minimum Hospital Stay for Hysterectomy	§ 38.2-3418.9 B	Each plan shall provide coverage for a laparoscopy-assisted vaginal hysterectomy including a minimum stay in a hospital of not less than 23 hours and coverage for a vaginal hysterectomy including a minimum stay in a hospital or not less than 48 hours as provided in this section.	
Diabetes Coverage	§ 38.2-3418.10	Each plan shall provide coverage for equipment, supplies and in-person outpatient self-management training and education, including medical nutrition therapy, for treatment of diabetes as specified this section.	
Hospice Care	§ 38.2-3418.11	Each plan shall provide 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 6 months and who elects to receive palliative care instead of curative care. Coverage for hospice services may be extended to include care when it cannot be demonstrated that the illness is terminal or for individuals with life expectancies of longer than six months. **Does not apply to short-term nonrenewable policies of not more than 6 months' duration.**	

Review Requirements	Federal and/or Virginia Citation	Comments	Page No.
Hospitalization for Anesthesia & Dental Procedures	§ 38.2-3418.12 A	Coverage shall be provided 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 which requires a hospital or outpatient surgery facility and general anesthesia for dental care treatment.	
Lymphedema	§ 38.2-3418.14 B	Coverage shall be provided for equipment, supplies, complex decongestive therapy, outpatient self-management training and education.	
Prosthetic Devices and Components	§ 38.2-3418.15 A	HMO shall offer and make available coverage for the health care services for medically necessary prosthetic devices, their repair, fitting, replacement and components. A covered person's coinsurance for in-network prosthetic devices must not be in excess of 30%.	
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 Dependents	§ 38.2-3525 E	Coverage for dependent student on medically necessary leave of absence: 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.	
EOC Must Be Provided	§ 38.2-4306 A 1	Each subscriber shall be entitled to an 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.	
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.	

Review Requirements	Federal and/or Virginia Citation	Comments	Page No.
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.	
Additional Provisions			
Primary Care Providers	14VAC5-211-140	Network plans requiring or providing for a primary care health professional to be designated must: 1. Allow each enrollee to designate any participating primary healthcare professional who is available to accept such individual. 2. A participating healthcare professional specializing in pediatrics and available to accept children may be designated as primary healthcare provider. Notice of these is required when carrier provides primary subscriber with a policy, certificate or contract of health insurance.	
Emergency Services	14VAC5-211-160 A 5	Plans must cover in and out-of-area emergency services, including ambulance services available 24 hours a day, 7 days a week.	
Nondiscriminatory Benefit Design	14VAC5-211-240 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, lawful occupation of the enrollee, or because of the frequency of utilization of services by the enrollee.	
Emergency Services Definitions	§ 38.2-4300	“Emergency medical condition means a medical condition manifesting itself by acute symptoms of sufficient severely, including severe pain, so that a prudent layperson reasonably expect the absence of immediate medical attention to result in a condition that places the physical or mental health of the individual in serious jeopardy, would result in serious impairment to bodily functions, or serious dysfunction of any bodily organ with respect to a pregnant woman, serious jeopardy to the health of the fetus”. “Emergency services means those health care services that are rendered by affiliated or nonaffiliated providers after the sudden onset of a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine to result in: (i) Serious jeopardy to the mental or physical health of the individual, (ii) Danger of serious impairment of the individual’s bodily functions, (iii) Serious dysfunction of any of the individual’s bodily organs, or (iv) In the case of a pregnant woman, serious jeopardy to the health of the fetus.	

Review Requirements	Federal and/or Virginia Citation	Comments	Page No.
		"Emergency services provided within the plan's service area shall include covered health care services from nonaffiliated providers only when delay in receiving care from a provider affiliated with the health maintenance organization could reasonably be expected to cause the enrollee's condition to worsen if left unattended". "Stabilize means to provide treatment that assures that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility, or with respect to a pregnant woman, that the woman has delivered, including the placenta".	
Basic Health Care Services	§ 38.2-4302 A 2 14VAC5-511-160 A	An HMO must provide or arrange for the provision of basic health care services.	
Provider Nondiscrimination	§ 38.2-4312	Providers operating within their scope of practice, license or certification cannot be discriminated against.	
Pharmacies; Freedom of Choice	§ 38.2-4312.1	If a plan has outpatient prescription drug benefits, the plan must allow for freedom of choice of pharmacies, if nonparticipating pharmacies agree in writing to accept reimbursement including copayment, at the same rates as participating pharmacies.	
Rates			
	14VAC5-130-60 A 14VAC5-130-60 B 14VAC5-130-65 Please see separate Rate Review Requirements Checklist	Rates associated with STLD insurance coverage offered to an association shall be filed with and approved by the Bureau in accordance with § 38.2-316.1 of the Code. The regulation specifies rate filing and actuarial memorandum requirements.	

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

Form Filing Review Checklist
GROUP ASSOCIATION SHORT-TERM LIMITED-DURATION HEALTH MAINTENANCE ORGANIZATIONS (HMOS)

I hereby certify that I have reviewed the attached group association short-term limited-duration health maintenance organizations filing and determined that it is in compliance with the group association short-term limited-duration health maintenance organizations checklist.

Signed: ____

Name (please print): _______________________________________

Company Name: ____

Date: ___________ Phone No: (   ) ______________ FAX No: (   ) ______________

E-Mail Address: ____________________________