Notice: This document is intended to assist carriers in preparing form and rate filings for Individual Short-term Limited-duration (STLD) Health Maintenance Organizations (HMOs) 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.	

Form Filing Review Checklist
INDIVIDUAL SHORT-TERM LIMITED-DURATION HEALTH MAINTENANCE ORGANIZATIONS

Review Requirements	Federal and/or Virginia Citation	Comments	Page No.
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	§ 38.2-3500 A 5; 14VAC5-100-50 1	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.	
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 ten-point.	
Table of Contents	14VAC5-110-50 B	Required for policy of more than 3 pages.	
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.	

Review Requirements	Federal and/or Virginia Citation	Comments	Page No.
		(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.	
Contents of Policy			
Name, Address and Telephone Number	14VAC5-211-210 B 1	Evidence of Coverage (EOC) must contain name, address and telephone number of the health maintenance organization (HMO).	
Effective Date and Term of Coverage	14VAC5-211-210 B 5	EOC must contain effective date and term of coverage.	
Assignment Restrictions	14VAC5-211-210 B 12	EOC must contain any assignment 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, limiting age for dependents.	
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 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.	
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.	

Review Requirements	Federal and/or Virginia Citation	Comments	Page No.
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.	
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-Contrib.	§ 38.2-4306 A 4 (d)	EOC must state premium amount.	
MCHIP Requirements			
		Regarding the plan submitted with this filing, is the provider network consistent with the information previously filed and approved under Section 38.2-5802? ☐ Yes ☐ No If no, this filing must include the following: 1. A detailed description of the criteria used to determine how a provider is included in the network or allocated to a tier within the network. 2. An explanation as to whether or not the network change or tiered network will result in any material change in the method of operation that is currently on file with the Financial Regulation Division. Pursuant to Administrative Letter 1998-11, any change that increases or decreases, or is likely to increase or decrease a health carrier's revenues, expenses, or net worth in an amount that exceeds 5% of the health carrier's current net worth qualifies as a material change that must receive prior approval from the Financial Regulation Division. 3. 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 § 38.2-4306 A 4 (f)	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 § 38.2-4306 A 4 (f)	Description of service area or areas shall be described in the policy.	

Review Requirements	Federal and/or Virginia Citation	Comments	Page No.
Complaints	§ 38.2-5803 A 3 § 38.2-4306 A 4 (e)	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 that have not been satisfactorily addressed by your plan, you may contact the Office of the Managed Care Ombudsman for assistance." Such notice must also include the toll-free telephone number, mailing address and electronic mailing address of the Office of the Managed Care Ombudsman.	
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			
Copayment Amount	14VAC5-211-90 A	Copayment must be shown in EOC as a specified dollar or as a coinsurance, not both.	
Copayment Notification	14VAC5-211-90 B	Plan shall keep copayment records, shall notify the 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.	
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 a coordination of benefits provision.	
Reasons for Termination	14VAC5-211-230 A	Plan may not terminate member, except for listed reasons: Failure to pay premiums, or fraud or deception. HMO must provide 31-day notice of termination.	
Termination Rules	14VAC5-211-230 B	EOC must contain terms and conditions under which coverage may be terminated.	

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.	
Nondiscriminatory Benefit Design	14VAC5-211-240 A	An HMO shall not unfairly discriminate against an enrollee on the basis of the age, sex, health status, race, color, creed, national origin, ancestry, religion, marital status, or lawful occupation of the enrollee.	
Subrogation	§ 38.2-3405 A	Policy cannot allow subrogation of any person's right to recovery for personal injuries from a third party.	
COB/Liability Coverage Prohibited	§ 38.2-3405 B 14VAC5-211 80 A	No plan shall require a beneficiary to pay back any benefits from the proceeds of a recovery by such beneficiary from any other source. This provision shall not prohibit an exclusion of benefits paid under worker's compensation laws or govt. programs nor shall it prohibit coordination of benefits between insurance contracts,	
Workers' Compensation Exclusion	§ 38.2-3405 D	Issuer shall not exclude coverage for any medical condition whenever benefits payable under workers' compensation are excluded from coverage.	
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 USFDA to treat cancer for which the drug has not been approved by USFDA 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. **Does not apply to short-term nonrenewable policies of not more than 6 months' duration that are not underwritten.**	
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 drugs and devices. **Does not apply to short-term nonrenewable policies of not more than 6 months' duration that are not underwritten.**	
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 that are not underwritten.**	
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 USFDA 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 that are not underwritten.**	

Review Requirements	Federal and/or Virginia Citation	Comments	Page No.
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	Policies using closed formularies must have a process to allow a medically necessary nonformulary prescription drug if the formulary drug is determined by the HMO to be inappropriate therapy. Requests must be acted on within one business day of receipt. Additional requirements apply to participating and nonparticipating providers and pharmacists.	
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.	
Partial Supply of Prescription Drugs	§ 38.2-3407.9:04 B	Any policy that includes prescription drug coverage shall provide that 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.	
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 that are not underwritten.**	

Review Requirements	Federal and/or Virginia Citation	Comments	Page No.
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. **Does not apply to short-term nonrenewable policies of not more than 6 months' duration that are not underwritten.**	
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. **Does not apply to short-term nonrenewable policies of not more than 6 months' duration that are not underwritten.**	
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 that are not underwritten.**	
Claims Paid to Enrollees for Services from Nonpar. Physicians	§ 38.2-3407.13:2	When an HMO follows a policy of sending its payment to enrollee, the certificate and explanation of benefit 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 that 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	Any policy that includes prescription drug coverage 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.	
Newborn Dependent Coverage	§ 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 policy shall be payable with respect to adopted children from the date of adoptive or parental placement with member for the purpose of adoption.	

Review Requirements	Federal and/or Virginia Citation	Comments	Page No.
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 that are not underwritten.**	
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 that are not underwritten.**	
Obstetrical Benefits; Coverage for Postpartum Services	§ 38.2-3414.1	Policy must have 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 that are not underwritten.**	
Pap Smears/Gynecologic 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 that are not underwritten.**	
Bones/Joint Coverage, TMJ Procedures	§ 38.2-3418.2 A	Plan 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. **Does not apply to short-term nonrenewable policies of not more than 6 months' duration that are not underwritten.**	
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 that are not underwritten.**	

Review Requirements	Federal and/or Virginia Citation	Comments	Page No.
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 that are not underwritten.**	
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 that are not underwritten.**	
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 that are not underwritten.**	
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 that are not underwritten.**	
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 that are not underwritten.**	
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 that are not underwritten.**	
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.	

Review Requirements	Federal and/or Virginia Citation	Comments	Page No.
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 that are not underwritten.**	
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.	
Coverage for Lymphedema	§ 38.2-3418.14 B	Coverage shall be provided for equipment, supplies, complex decongestive therapy, outpatient self-management training and education.	
Coverage for 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.	
Cancellation by Enrollee	§ 38.2-3503 A 13	The enrollee 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.	
Cancellation by Company	§ 38.2-3504 8	A company may cancel the policy at any time by written notice. See statute for complete details.	

Review Requirements	Federal and/or Virginia Citation	Comments	Page No.
Preexisting Conditions Provisions	§ 38.2-3514.1	Preexisting conditions limitation provision is for no longer than 12 months from the effective date of coverage, and has a 12-month look back period. Coverage shall credit the time a person was covered under previous individual or group medical policies within 30 days of the new coverage. **Does not apply to short-term nonrenewable policies of not more than 6 months' duration that are not underwritten.**	
Renewability (Individual)	§ 38.2-3514.2 A	Renewal for a period up to 36 months is at the option of the individual, except for specific reasons expressed in the statutes. **Does not apply to short-term nonrenewable policies of not more than 6 months' duration that are not underwritten.**	
Basic Health Care Services	§ 38.2-4302 A 2	An HMO must provide or arrange for the provision of basic health care services.	
Deductible	§ 38.2-4303 A 8	An enrollee may be required to pay an annual deductible.	
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.	
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.	
Rates			
	14VAC5-130-60 A 14VAC5-130-60 B 14VAC5-130-65 Please see separate Rate Review Requirements Checklist	Rates associated with individual STLD insurance coverage 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
INDIVIDUAL SHORT-TERM LIMITED-DURATION HEALTH MAINTENANCE ORGANIZATIONS

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

Signed: _____

Name (please print): _____

Company Name: _____

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

E-Mail Address: _____