PENNSYLVANIA INSURANCE DEPARTMENT
ACCIDENT AND HEALTH BUREAU - POLICY REVIEW DIVISON

The Pennsylvania Insurance Department, Accident and Health Bureau, Policy Review Division will require the following forms to be submitted:

-- Contract forms between a HMO and its group subscribers, including the Evidence of Coverage forms, setting forth the Corporation's contractual obligations to provide basic health services.

-- Individual Direct Pay Conversion Contract providing basic health services by a HMO to its subscribers. (This contract form is required for execution of the conversion right from a group contract to an individual contract.) The conversion contract may be submitted within a reasonably short period after the group contract form has been found satisfactory to the Department. A COA approval will not be withheld if it is agreed that the conversion contract will be furnished in a timely manner. The conversion contract shall offer the same level of benefits as are available to a group subscriber.

-- The form and content of all contracts between a HMO and its individual direct pay subscribers (if applicable).

-- Proposed general subscriber literature, including an identification card.

-- Contract application and application for individual enrollment form, including any health or evidence of insurability forms.

-- Proposed benefit booklets, educational material or marketing material pertaining to the basic health services offered by the HMO to subscribers.

-- Riders (to provide benefits other than basic health services), must be presented in a form that includes the specific unique form ID # in the lower left hand corner on the face of the form, a signature line for the signature of a plan officer and the name of the plan.

NOTE: the Insurance Department is willing to provide you, upon request, previously accepted contract forms to guide you in submitting forms in acceptable format and content. If you require a set of these contracts, please contact the Department.

The following CHECKLIST has been enclosed to aid you in the preparation of the contract forms that will comply with PA Laws and Regulations. Please indicate on the Checklist, where appropriate, the specific location and form where the required compliance item may be found within your filing.

PENNSYLVANIA INSURANCE DEPARTMENT
HMO CHECKLIST FOR FILING CONTRACT FORMS AND RELATED MATERIAL TO THE ACCIDENT & HEALTH POLICY REVIEW DIVISION

A person designated by the HMO should review each of these requirements and verify that the submitted forms comply. In addition, it is necessary for the designated person to indicate, where requested, the form number and location where a specific requirement has been satisfied.

☐1. Contracts or Evidence of Coverage must be filed in duplicate, for final approval. (31 Pa. Code Section 301.62) It is only necessary to file one complete set of forms for review purposes, as a working copy, until the forms are ready for final approval.

☐2. Form Number shall be identified with a distinguishing form number on the face cover of form. (Insert Form Number in the lower left hand corner of the face page of all forms). (31 Pa. Code Section 301.62)

☐3. Contract Forms & Evidence of Coverage shall be submitted in final print, in the form intended for actual issue for formal filing. (31 Pa. Code Section 301.62)

☐4. Blank Spaces shall be completed with hypothetical data demonstrating the purpose of the forms. (31 Pa. Code Section 301.62)
All intended variability must be provided. A separate Explanation of Variability Statement must accompany the form to explain the intended variability, and disclose the actual language, amounts, durations, etc. intended to appear within the form at disclosed times.

☐5. Definitions in contracts or evidence of coverage must be in Alphabetical Order. (31 Pa. Code Section 301.2)

☐6. Definitions in contracts or evidence of coverage must not contradict the definitions in Section 301.2.

____ Affiliated Provider or Participating Provider
____ Basic Health Services (DOH 28 Pa. Code Sec. 9.2)
____ Contractholder
____ Evidence of Coverage
____ Group Contract
____ Medical Necessity or Medically Necessary
____ Member or Enrollee
____ Primary Care Physician
____ Provider
____ Service Area
____ Subscriber

☐7. Disclosure Requirements (31 Pa. Code Section 301.62)

____ a. Contract Forms & Evidence of Coverage must clearly and prominently state that coverage is limited to services provided by affiliated providers, except in emergency situations or when authorized in advance by an affiliated provider.
Identify Forms and Page Reference where this requirement is satisfied:_____

_____

____ b. Contract Forms & Evidence of Coverage shall clearly explain the limitations on emergency and out-of-area services.
Identify Forms and Page Reference where this requirement is satisfied:_____
_____

____ c. Contract Forms & Evidence of Coverage shall contain complete, accurate and easily understood description of contract benefits, limitations and exclusions.

____ d. Contract Forms & Evidence of Coverage shall state that changes in premium rates and contract forms are subject to prior review and approval of the Department.
Identify Forms and Page Reference where this requirement is satisfied:_____
_____

☐8. Emergency Benefits & Services: (31 Pa. Code Section 301.62)
____ a. Contract & Evidence of Coverage shall contain a specific description of benefits and services available for emergencies 24 hours a day, 7 days a week, including disclosure of restrictions on emergency benefits and services. Identify Forms and Page Reference where this requirement is satisfied:_____
_____.

____ b. The forms shall explain the procedures to follow to secure medically necessary emergency health services.
Identify Forms and Page Reference where this requirement is satisfied:_____
_____.

____ c. Emergency Care shall be covered in and out of the Service Area.
Identify Forms and Page Reference where this requirement is satisfied:_____
_____.

____ d. No emergency room copayment in excess of Primary Care Copayment may be charged if the member has been referred to the emergency room by a Primary Care Physician or the HMO and the services could have been performed in the Primary Care Physician's Office.
Identify Forms and Page Reference where this requirement is satisfied:_____
_____

☐9. Copayment Requirements: (31 Pa. Code Section 301.62) Contract Forms and Evidence of Coverage and Marketing Literature shall contain a Complete, Accurate and Easily Understood Description of Copayment Requirements.
____ a. Copayments shall be described in specific dollar amounts.
Identify Forms and Page Reference where this requirement is satisfied:_____
_____

HMO CHECKLIST FOR FILING CONTRACT FORMS & RELATED MATERIAL

☐10. Arbitration: (31 Pa. Code Section 301.62) Contract Forms and Evidence of Coverage may not require a member to submit to binding arbitration for settlement of a dispute between the member and the HMO.

☐11. Subrogation: (31 Pa. Code Section 301.62) If the Contract contains a Subrogation or Reimbursement Provision, the provision shall state that the right of Subrogation or Reimbursement is not enforceable if prohibited by statue or regulation.
Identify Forms and Page Reference where this requirements is satisfied:_____
_____

☐12. Transplant Procedures: (31 Pa. Code Section 301.62) Benefits for covered Transplant Procedures shall include coverage for the medical expenses of a live donor to the extent that those medical expenses are not covered by another program.
Identify Forms and Page Reference where this requirement is satisfied:_____
_____

NO GROUP OR INDIVIDUAL PREEXISTING CONDITION PROVISIONS ARE PERMITTED UNLESS THE PROVISION HAS BEEN SPECIFICALLY APPROVED BY THE DEPARTMENT OF HEALTH.
NO GROUP OR INDIVIDUAL PREEXISTING CONDITION WILL BE APPROVED BY THE INSURANCE DEPARTMENT THAT DOES NOT COMPLY WITH THE FOLLOWING REQUIREMENTS:

☐13. Preexisting Conditions: No Preexisting Condition may be more restrictive than the following: (31 Pa. Code Section 301.62, as amended by Act 29 of 1997)

____ a. A Preexisting Condition relates to a condition (whether physical or mental), regardless of the cause of the condition, for which an individual received medical advice, diagnosis, care, or treatment within the six month period ending on the enrollment date.

____ b. Such exclusion extends for a period of not more than 12 months (or 18 months in the case of a late enrollee) after the enrollment date; but reduced by the aggregate of the periods of creditable coverage applicable to the participant or beneficiary as of the enrollment date; and

____ c. Such preexisting condition exclusion shall not be applicable to newborns who, as of the last day of the 30 day period beginning with the date of birth, is covered under creditable coverage; and

____ d. Such preexisting condition exclusion shall not be applicable to any child who is adopted or placed for adoption before attaining 18 years of age and who, as of the last day of the 30 day period beginning on the date of the adoption or placement for adoption, is covered under creditable coverage; and

____ e. Such preexisting condition exclusion shall not be applicable to pregnancy or to Genetic information as a preexisting condition.

When was the Department of Health's approval for the inclusion of a Pre-Existing Condition secured?_____.
Identify Forms and Page Reference where the above requirements are satisfied:_____
_____.

____ f. If the Contract includes a Preexisting Condition Limitation, the Enrollment Form shall contain a question and provision for answer in the following form: "NOTICE: The following question must be answered: Do you understand that the HMO will not provide coverage during the first __ month(s) of enrollment for health care services required for the treatment of any disease or physical condition which required medical advice or treatment within 6 months prior to enrollment?"

____ g. NOTE: Contracts may not utilize Individual Impairment Riders whereby coverage for a Specific Condition or a Specific Individual is limited or excluded.

☐14. Termination of Coverage: (31 Pa. Code Section 301.62)

____ A. The Contract and Evidence of Coverage shall clearly state the conditions upon which cancellation or termination may be effected by the HMO or the Member.

____ B. No HMO may cancel or terminate coverage of services provided a Member under an HMO Contract EXCEPT for one of the following reasons: (31 Pa. Code Section 301.62)

____ 1. Failure to Pay the Amount Due under the Contract.

____ 2. Fraud or Material Misrepresentation in the use of Services or Facilities.

____ 3. Violation of Material Terms of the Contract.

____ 4. Failure to continue to meet the Eligibility Requirements under a Group Contract, if a Conversion Option is offered.

____ 5. Termination of the Group Contract under which the Member was covered.

____ 6. Failure of the Member and the Primary Care Physician to establish a Satisfactory Patient-Physician relationship if:

____ a. It is shown that the HMO has, in good faith, provided the Member with the opportunity to select an alternative primary care physician.

____ b. The Member has repeatedly refused to follow the plan of treatment order by the Physician.

____ c. The Member is notified in writing at least 30 days in advance that the HMO considers the Patient-Physician Relationship to be unsatisfactory and specific changes are necessary in order to avoid termination subject to HMO Grievance Procedure.

____ C. No HMO may cancel or terminate a Member's Coverage for services provided under an HMO Contract on the basis of the status of the Member's Health.

____ D. No HMO may cancel or terminate a Member's Coverage for services provided under an HMO Contract on the basis that the Subscriber has exercised rights under the HMO's Grievance System by registering a complaint against the HMO.

____ E. No HMO may cancel or terminate a Member's Coverage for services provided under an HMO Contract without giving the Member written notice of termination including the reason for termination.

____ 1. Termination is not effective for (15) days from the date of mailing.

____ 2. If the notice is not mailed, effective termination is from the date of delivery.

____ 3. For termination due to nonpayment of premium, the grace period shall be at least (30) days.

____ F. A Member's misuse of a Membership Card will not result in Termination of Coverage for the Member's Entire Family unless the Member who misuses the Membership Card is the Subscriber.

____ G. A Member's failure to establish and maintain an acceptable Physician-Patient Relationship with a Provider will not result in Termination for the Member's Entire Family unless the Member is the Subscriber.

Identify Forms and Page Reference where these requirements are satisfied:_____
_____

____ H. If a Member is an Inpatient in a Hospital or Skilled Nursing Facility on the date coverage is due to Terminate, Coverage shall be extended until the Member is Discharged, but may be terminated when the Contractual Benefit Limit has been reached.
Identify Forms and Page Reference where this requirement is satisfied:_____
_____

☐15. Coordination of Benefits: (31 Pa. Code Section 301.62)
The Group Contract may contain a C.O.B. provision that is consistent with that applicable to other carriers in this Commonwealth. (NAIC MODEL C.O.B. REGULATION OF JULY 1985)
____ a. Provisions or rules for coordination of benefits established by an HMO may not relieve an HMO of its duty to provide or arrange for a covered health service to a Member because the Member is entitled to coverage under another contract, policy or plan, including coverage provided under government programs. **The HMO is required to provide health care services first and then may seek coordination of benefits.**
Identify Forms and Page Reference where this requirement is satisfied:_____
_____

☐16. Grace Period: (31 Pa. Code Section 301.62) - The Contract or Evidence of Coverage shall provide for a grace period of at least (30) days for the payment of premiums, except the first, **during which coverage shall remain in effect.**
____ a. The Contract Holder shall remain liable for the payment of the premium for the time coverage was in effect during the grace period.
____ b. The Member shall remain liable for Copayments owed.
Identify Forms and Page Reference where this requirement is satisfied:_____
_____

☐17. Claims: (31 Pa. Code Section 301.62) - The Contract and Evidence of Coverage shall contain Procedures for Filing Claims that include:
____ a. A Required Notice to the HMO.
____ b. How & When Claim Forms are obtained, if they are required.
____ c. Requirements for Filing Proper Proof of Loss.
____ d. Time Limit for Payment of Claims.
Identify Forms and Page Reference where these requirements are satisfied:_____
_____

☐18. Medical Necessity Administration: (31 Pa. Code Section 301.62). Authorization by the Member's Primary Care Physician or Other Physician providing service at the direction of the Primary Care Physician, shall constitute proof of medical necessity for purposes of determining the Member's potential liability.

Identify Forms and Page Reference where this requirement is satisfied:_____

_____

☐19. Minimum Mandated Benefits:

____ A. Coverage for Mammographic Examinations: (Pa. Insurance Law, Chapter 2, Section 632 (40 P.S. Subsection 764c)) The Minimum coverage required shall include all costs associated with a mammogram every year for women (40) years of age or older and with any mammogram based on a physician's recommendation for women under (40) years of age. Prior to payment for a screening mammogram, insurers shall verify that the mammograph service provider is properly licensed by the Department in accordance with the Act of July 9, 1992 (P.L. 449, No.#93), known as the "Mammography Quality Assurance Act."
Identify Forms and Page Reference where this requirement is satisfied:_____

_____

____ B. Coverage for Annual Gynecological Examinations and Routine Pap Smears: (Women's Preventative Health Services Act), Pa. Insurance Law, Chapter 2, Section 633. Mandated Coverage shall include:

____ 1. Annual Gynecological Examination, including a pelvic examination and clinical breast examination.

____ 2. Routine Pap Smears in accordance with the recommendations of the American College of Obstetricians and Gynecologists.

Copayment & Coinsurance provisions applicable to other medical services may be applied to the annual gyn exam and routine pap smear benefit.
Identify Forms and Page Reference where this requirement is satisfied:_____

_____

____ C. Coverage for Alcohol and Drug Substance Abuse: (Pa. Insurance Law, Chapter 2, Section 602-A, 603-A, 604-A, 605-A, & 606-A).

____ 1. Section 603-A, Inpatient Detoxification provided in either a Hospital or an Inpatient Nonhospital Facility that has a written affiliation agreement with a Hospital for Emergency, Medical and Psychiatric or Psychological support services, meets minimum standards for client-to-staff ratios and staff qualifications, which shall be established by the Department of Health and is licensed as an alcoholism and/or drug addiction treatment program.

The following services shall be covered: Lodging and dietary services; Physician, Psychologist, Nurse, Certified Addictions Counselors and Trained Staff services; Diagnostic X-ray, Psychiatric, Psychological and Medical Laboratory Testing; Drugs, Medicines, Equipment Use and Supplies.

Treatment under this section may be subject to a Lifetime Limit for any covered individual of (4) admissions for detoxification, and reimbursement per admission may be limited to (7) days of treatment or an equivalent amount.
Identify Forms and Page Reference where this requirement is satisfied:_____

_____

____ 2. Section 604-A, Nonhospital Residential Alcohol or Other Drug Services provided in a Facility which meets minimum standards for client-to-staff ratios and staff qualifications

shall be established by the Office of Drug and Alcohol Programs and is appropriately licensed by the Department of Health as an alcoholism or drug addiction treatment program. A licensed physician or licensed psychologist must certify the insured as a person suffering alcohol or other drug abuse or dependency and refer the insured for the appropriate treatment.
The following services shall be covered under this section: Lodging and dietary services; Physician, Psychologist, Nurse, Certified Addictions Counselors and Trained Staff services; Rehabilitation Therapy and Counseling; Family Counseling and Intervention; Psychiatric, Psychological and Medical Laboratory Tests; Drugs, Medicines, Equipment Use and Supplies.
Treatment under this Section shall be covered for a minimum of (30) days per year for residential care. Additional days shall be available as provided under Section 605-A(d). Treatment may be subject to a Lifetime Limit, for any covered individual, of (90) days.
Identify Forms and Page Reference where this Requirement is satisfied:_____
_____

____ 3. Section 605-A, Outpatient Alcohol or Other Drug Services shall be provided in a Facility appropriately licensed by the Department of Health as an Alcoholism or Drug Addiction Treatment Program. A licensed Physician or licensed Psychologist must certify the insured as a person suffering from alcohol or other drug abuse or dependency and refer the insured for the appropriate treatment:
The following services shall be covered under this Section: Physician, Psychologist, Nurse, Certified Addictions Counselor and Trained Staff services; Rehabilitation Therapy and Counseling; Family Counseling and Intervention; Psychiatric, Psychological and Medical Laboratory Tests; Drugs, Medicines, Equipment Use and Supplies.
Treatment shall be covered for a minimum of (30) outpatient, full-session visits or equivalent partial visits per year. Treatment may be subject to a Lifetime Limit, for any covered individual, of (120) Outpatient, Full-Session Visits or Equivalent Partial Visits. In Addition: Treatment shall include a minimum of (30) separate sessions of outpatient or partial hospitalization services per year, which may be exchanged on a two-to-one basis to secure up to (15) additional Nonhospital, Residential Alcohol Treatment days.
Identify Forms and Page Reference where this Requirement is satisfied:_____
_____

____ 4. Section 606-A, Deductibles, Copayment Plans and Prospective Payment: Reasonable Deductible or Copayment plans or Both, after approval by the Insurance Commissioner, may be applied to benefits paid to or on behalf of patients during the course of alcohol or other drug abuse or dependency treatment.

____ In the first instance or course of treatment, no deductible or copayment shall be less favorable than those applied to similar classes or categories of treatment for physical illness generally in each policy. (For Inpatient Detoxification the Deductibles/CoPays cannot exceed the inpatient deductible/copays applicable to medical services.) (For Rehabilitation the Deductible/Copays may not exceed the Skilled Nursing Facility amounts.) (For Outpatient Services the Copays are limited to the Specialist Office Visit Copay amount.)

Identify Forms and Page Reference where this Requirement is satisfied:_____
_____

____ D. Health Insurance Coverage for Newborn Children, (Pa. Insurance Law, Chapter 4, Article IV, (40 P.S. Subsection 753.2). The Coverage for Newborn Children shall consist of coverage of Injury or Sickness including the necessary care and treatment of medically diagnosed congenital defects, birth abnormalities, prematurity and routine nursery care, but need not include routine well-baby care, immunizations and medical examinations or test not necessary for the treatment of a covered injury, illness, defect, deformity or disease except to the extent that such coverage is provided to the insured or for dependent children under the same class of coverage. The Contract may require that notification of birth of a newborn child and payment of the required premium or fees must be furnished to the insurer, or nonprofit service or indemnity corporation within 31 days after the date of birth in order to have coverage continue beyond such 31 day period. If the child is not eligible for continued coverage under the contract, the insured may apply for a conversion contract for the child.
Identify Forms and Page Reference where this Requirement is satisfied:_____
_____

____ E. Childhood Immunization Insurance Act, (Pa. Insurance Law, Chapter 4, Article IV, Section 3), requires coverage for child immunizations. Coverage shall include medically necessary booster doses of all immunizing agents used in child immunizations.
Benefits shall be subject to Copayment and Coinsurance provisions to the extent that other medical services covered by the policy are subject to those provisions. **Benefits shall be Exempt from Deductible or Dollar Limit Provisions.** This Exemption must be explicitly provided for in the policy.
Identify Forms and Page Reference where this Requirement is satisfied:_____
_____

____ F. Chemotherapy, (PA Insurance Law, Chapter 2, Subsection 631 (40 P.S. Subsection 764b), coverage includes benefits for cancer chemotherapy and cancer hormone treatments and services which have been approved by the FDA for general use in treatment of cancer. The covered individual shall be entitled to benefits whether performed in a physician's office, in an outpatient department of a hospital, or in any other medically appropriate setting.
Identify Forms and Page Reference where this Requirement is satisfied:_____
_____

☐20. Unfair Insurance Practices Act, (Pa. Insurance Law, Chapter 4, Article II). Unfair Methods or Competition and Unfair or Deceptive Acts or Practices - No person shall engage in any trade practice which is defined or determined to be an unfair method of competition or an unfair or deceptive act or practice in the business of insurance pursuant to this act. All forms must be in compliance with this Act.

☐21. Department of Health Regulations, Chapter 9, Subchapter E, Operational Standards for a HMO.

____ a. Subsection 9.72, Basic Health Services: At least the following Basic Health Services must be provided:

____ 1. Emergency Care necessary to preserve the Life or stabilize health, Available on an Inpatient or an Outpatient Basis 24 Hours per day, (7) days per week.

HMO CHECKLIST FOR FILING CONTRACT FORMS & RELATED MATERIAL

Identify Forms and Page Reference where this Requirement is satisfied:_____

_____

____ 2. Ambulatory Physician Care - Medically Necessary and Preventive Health Services performed, prescribed, or supervised by physicians for patients not confined to bed in an institution or at home.

Identify Forms and Page Reference where this benefit is provided:_____

_____

____3. Inpatient Hospital Care - Medically Necessary Hospital Service affording inpatient treatment to subscribers in a general hospital for a minimum of (90) days per contract or calendar year. Hospital Services include: Room and Board, General Nursing Care, Special Diets when Medically Necessary, Use of Operating Room and related facilities, use of Intensive Care Unit and Services, X-ray, Laboratory, and Other Diagnostic Tests, Drugs, Medications, Biologicals, Anesthesia and Oxygen Services, Special Duty Nursing when Medically Necessary, Physician Therapy, Radiation Therapy, Inhalation Therapy, Administration of Whole Blood and Blood Plasma and Short-term Rehabilitation Services.

Identify Forms and Page Reference where these benefits are provided:_____

_____

____ 4. Inpatient Physician Care - Accepted and Medically Necessary Health Services performed, prescribed, or Supervised by Physicians within a Hospital for registered bed patients, including diagnostic and therapeutic care.

Identify Forms and Page Reference where this benefit is provided:_____

_____

____ 5. Outpatient and Preventive Medical Services - Services, such as well baby care, immunizations, and periodic physical examinations provided with the goal of protection against and early detection and minimization of the ill effects and causes of disease or disability.

Identify Forms and Page Reference where these benefits are provided:_____

_____

☐22. A HMO shall provide Basic Health Services to its subscribers as needed and without unreasonable limitations as to time and cost. Nominal copayments may be imposed upon Basic Health Services subject to the following conditions:

____ a. To insure that Copayments are not a barrier to the utilization of health services or membership in the organization, a HMO shall neither impose Copayment Charges that exceed 50% of the Total Cost of Providing any Single Service to its subscribers nor 20% of the Total Cost of providing all basic health services. (DOH: 28 Pa. Code Section 9.72)

____ b. No Copayment may be imposed on any Subscriber covered under his Contract in any Calendar Year when the Copayments made by the Subscriber in the Calendar Year total 50% of the Total Annual Premium Cost which the Subscriber will be required to pay if enrolled under an

option with no Copayments. The Subscriber must demonstrate that Copayments in that amount have been paid during the Calendar Year. (DOH: 28 Pa. Code Section 9.72)

____c. Copayment Limits established by the Department of Health and Insurance jointly for HMO Benefit Packages are as follows:

1. $15.00 Maximum Co-pay on PCP Office Visit and $25.00 Maximum for Specialist
2. $625.00 Maximum Co-pay for Inpatient Hospital Care

Contact the Departments for the most recent listing of limitations.

☐23. Reasonable Exclusions, such as customarily found in Group Health Insurance Policies (PID: 31 Pa. Code Section 89.77), will be permitted. (DOH: 28 Pa. Code Section 9.72)

☐24. A HMO may provide Services in addition to Basic Health Services, Other Health Services such as Cosmetic Surgery, Prescription Drug Coverage, Dental Coverage, Mental Health Benefits and similar services which a voluntarily enrolled population may require to maintain physical and mental health. (DOH: 28 Pa. Code Section 9.72) (Note: When presenting these additional services on separate rider forms, it is necessary to identify the name of the Plan, identify the rider form with a specific unique form identification number in the lower left hand corner of the face of the form and provide for a signature of the appropriate Plan Officer).

☐25. A HMO shall have a written grievance procedure for prompt and effective resolution of Subscriber grievances. This procedure shall be set forth with the Contract and any Evidence of Coverage Forms. (DOH: 28 Pa. Code Section 9.73)

☐26. A HMO shall have a written Quality Assurance Procedure to provide ongoing review, analysis, assessment and subsequent action or improvement of the quality of health care services delivered to its subscribers. (DOH: 28 Pa. Code Section 9.74) It is not necessary to submit this Procedure with your actual contract form submission to the Accident and Health, HMO/PPO Form Review Division.

☐27. A HMO shall make available to each subscriber a primary care physician to supervise and coordinate the health care of the subscriber. (DOH: 28 Pa. Code Section 9.75)

____ a. All referrals for Specialty Care, except in Emergency situations, shall be approved by the Subscriber's Primary Care Physician.

☐28. When a Subscriber is referred by a HMO or by a HMO Physician to a Nonparticipating Specialist, the Subscriber shall incur no financial liability above that which he would have incurred had he been referred to a Participating Specialist. (DOH: 28 Pa. Code Section 9.75) Identify Forms and Page Reference where this requirement is satisfied:_____

_____

☐29. A HMO shall have written procedures governing the availability of frequently utilized services contracted for by Subscribers, including at least the following: (DOH 28 Pa. Code Section 9.75)

____a. Well-patient examinations and immunizations.
____b. Emergency telephone consultation 24-hours per day, 7 days per week.
____c. Treatment of acute emergencies.

____e. Treatment of chronic illness.

☐30. A HMO shall have a written procedure for payment of emergency health services provided outside of its service area. (DOH: 28 Pa. Code Section 9.75)

☐31. A HMO shall develop and adhere to written procedures for informing Subscribers of at least the following Subscriber Rights:
(DOH: 28 Pa. Code Section 9.77)

____a. Subscriber has the right to timely and effective redress of Grievances through a system established under Section 9.73 (relating to operational standards regarding Subscriber Grievance Systems).

____b. Subscribers have the right to have HMO Literature and Materials for his use written in a manner which truthfully and accurately provides relevant information so that it is easily understood by a person of average intelligence.

____c. A Subscriber has the right to have all records pertaining to his medical care treated as Confidential unless disclosure is necessary to interpret the application of his contract to his care or unless disclosure is otherwise provided for by law.

☐32. A HMO shall offer to each Subscriber who becomes ineligible to continue as part of a Group Subscriber Agreement, a Non-Group Subscription Agreement offering the same level of benefits as are available to a Group Subscriber. A reasonable premium differential may be charged to a Non-Group Subscriber in consideration of the somewhat higher administrative expenses involved in direct payment of premiums. (DOH: 28 Pa. Code Section 9.77)

☐33. No HMO shall Expel or Refuse to Reenroll any Member solely because of his health care needs nor refuse to Enroll Individual Subscribers of a Group on the basis of the Health Status or Health Care Needs of such Individual. (DOH: 28 Pa. Code Section 9.77)

☐34. Act 150 of 1994, Amending Title 23 (Domestic Relations) of the Pa. Consolidated Statues, implementing the provisions of the Omnibus Budget Reconciliation Act of 1993 relating to required State Laws for Medical Child Support; and further providing for improvements in child support enforcement and for acknowledgment and claim of paternity. TO THE MAXIMUM EXTENT PERMITTED BY FEDERAL LAW, THE FOLLOWING OBLIGATIONS SHALL APPLY TO A HMO:

____ a. A HMO must receive, process and pay claims to a custodial parent who has complied with the HMO's existing claim procedures and presented to the HMO a copy of the Court Order (providing for payment of medical expenses and/or maintenance of medical insurance coverage on behalf of the child by the custodial parent or a release signed by the insured permitting the insurer to communicate directly with the custodial parent; to permit the Custodial Parent or the Provider or, in the case of Medical Assistance Patients, to the Department of Public Welfare; to provide such information to the Custodial Parent as may be necessary to obtain benefits, including copies of benefit booklets, insurance contracts and claims information

____ b. If coverage is made available for dependents of the insured, to make such coverage available to the insured's children without regard to Enrollment Season Restrictions, Whether the Child was born out of wedlock, Whether the Child is claimed as a Dependent on the Parent's Federal Income Tax Return, Whether the Child resides in the HMOs Service Area, the amount of

support contributed by a parent, the amount of time the child spends in the home or the custodial arrangements for the Child.

____ c. HMO must permit the enrollment of children under Court Order upon application of the Custodial Parent, Domestic Relations Section or the Department of Public Welfare, within (30) days of receipt by the HMO of the Order.

____ d. HMO must not disenroll or eliminate coverage of any Child unless the HMO is provided satisfactory written evidence that a Court Order requiring coverage is no longer in effect or that the Child is or will be enrolled in comparable Health Coverage through another insurer which will take effect no later than the effective date of such disenrollment.

____ e. HMO shall receive, process and pay claims (whether or not on behalf of a Child), including electronically submitted claims, submitted by the Department of Public Welfare within the time permitted by law without imposing any patient signature requirement or other requirement different from those imposed upon Providers, Agents or Assignees of any insured individual.

____ f. HMO will provide the Custodial Parent who has complied with these provisions the same notification of termination or modification of any Health Care Coverage due to Nonpayment of premiums or other reason as is provided to other insureds under the policy and to not take into account the fact than any individual, whether or not a child, is eligible for or is being provided medical assistance when enrolling that individual or when making any payments for benefits to that individual or on the individual's behalf.

☐35. Act 152 of 1994, Requiring HMOs to cover adopted children.
Plans which provide hospital or medical/surgical coverage to family members, shall also provide coverage for adopted children of the insured, subscriber or enrollee on the same terms and conditions as other covered dependent children. No policy, certificate or subscriber contract shall contain preexisting conditions limitations, or insurability, eligibility or health underwriting approval which treats adopted children differently than natural born children. The coverage required is effective from the date of placement for the purpose of adoption and continues until the placement is disrupted prior to legal adoption and the child is removed from placement. "Placement" means the assumption and retention by a person of a legal obligation for total or partial support of a child in anticipation of adoption of the child. The child's placement with a person terminates upon the termination of such legal obligation. Coverage is not contingent upon whether a final adoption order is ever issued. Newborns placed for adoption or adopted must be provided Newborn coverage the same as any other newborn child. The adopted child shall be treated the same as any other dependent under the contract.

☐36. Act 165 of 1994, Effective February 26, 1995, provides that All applications for insurance and all claim forms shall contain or have thereto the following notice: "Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties." Wording is required verbatim. This statement shall be applicable to Group Application and Group Enrollment Forms as well as Individual Application Forms.

☐37. Act 85 of 1996, Effective 8/31/96, known as The Health Security Act, mandates coverage for maternity of 48 hours for a normal vaginal birth and 96 hours following a cesarean section.

discharge occurs, for which no copayment, coinsurance, or deductible may be charged. This information need not be included in the forms; however, the company must meet all the requirements of this act, including home health visit(s) upon early discharge.

☐38. Act 112 of 1996, Effective January 7, 1997 - Emergency Room Reimbursements. This Act requires insurers to reimburse insureds or providers for medically necessary services provided to treat a medical emergency. Hospital Emergency Facilities are required to provide insurers with information on the patient's presenting symptoms when they submit a claim. Insurers must consider both the presenting symptoms and the actual services provided when processing claims for payment.

☐39. Act 191 of 1996, Effective June 20, 1997 - Medical Foods Insurance Coverage Act. The Act requires insurers to cover the cost of medical foods and prescribed nutritional formulas used to treat Phenylketonuria (PKU) and related disorders. Benefits for PKU are subject to the same coinsurance or copayments as other covered medical services, but are exempt from deductible provisions. They are not exempt from dollar limits.

End of Summary.

Today's Date:_____

Name of Person selected by the HMO Applicant and designated to verify that the forms submitted to the Pennsylvania Insurance Department, Accident & Health, HMO/PPO Forms Review Division, conform to the requirements set forth in the above checklist.

Name:_____X_____
(Print Name) (Signature)

Title: _____

Telephone: ( ) _____-_____, Extension:_____.