Review Requirements Checklist
GROUP MEDICARE SUPPLEMENT INSURANCE
(For Standardized Contracts with Effective Dates on or after June 1, 2010)

REVIEW REQUIREMENTS	REFERENCES	COMMENTS
General Filing Requirements		
Transmittal Letter	14VAC5-100-40	**For Paper Filings:** Must be submitted in duplicate for each filing, describing each form, its intended use and kind of insurance provided.
	14VAC5-100-40 1	Forms submitted and described in transmittal letter must have a number that consists of digits, letters or a combination of both.
	14VAC5-100-40 2	Must clearly indicate if forms are replacements, revisions, or modifications of previously approved forms and describe the exact changes that are intended.
	14VAC5-100-40 3	Certification 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 form is intended.
	14VAC5-100-40 6	**For Paper Filings:** At least one copy of each form must be included in the filing. A duplicate copy of forms must be submitted if the company wants a “stamped” copy of forms for its records. A stamped self-addressed return envelope is required. The letter of transmittal must be addressed to: State Corporation Commission, Bureau of Insurance, P. O. Box 1157, Richmond, VA 23218.
	Administrative Letter 1983-7	Must include the name and individual NAIC number of the company for which the filing is made.
Variable Language		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, other; and intended use.
		(ii) Identification of changes in benefits and premiums (previously approved or filed forms). [Place changed contract provisions (red-lined or highlighted) in Supporting Documentation].
		(iii) Identification of SERFF or state tracking number for the previously approved or filed form for which the new form revises, replaces, or is intended to be used.

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		(iv) A statement as to whether any other regulatory body has withdrawn approval of the form because the form contains one or more provisions that were deemed to be misleading, deceptive or contrary to public policy.
HELP TIP:		If a form or rate filing is submitted as new in Virginia, but was previously disapproved or withdrawn in Virginia, please provide details such as the state tracking information, form number, and the date that the form or rate filing was disapproved or withdrawn, if available.
Rate Changes		(i) Specify the number of affected policyholders.
		(ii) Provide the reason(s) for the proposed change(s).
		(iii) Include a statement regarding an increase, decrease, revision of former rates.
		(iv) Specify the percentage amount(s) of the change(s).
Forms		
Form Number	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.") must prominently appear on cover sheet of all policies and other forms. Home office address of insurer must prominently appear on each policy.
Final Form	14VAC5-100-50 3	Form must be submitted in the final form in which it will be issued and completed in "John Doe" fashion to indicate its intended use.
Application	14VAC5-100-50 4	Any policy form which is to be issued with an attached application, must be filed with a copy of the application completed in "John Doe" fashion to indicate its intended use. (If an application was previously approved, advise date of approval).
Type Size	14VAC5-100-50 5	Forms must be printed with type size of at least 8-point type.
Contents of Policies	§ 38.2-305 A	Each policy/contract shall specify the: (1) The names of the 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) The conditions pertaining to 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.
Arbitration	§ 38.2-312	Contract may not deprive courts of Virginia jurisdiction in actions against insurer. Arbitration may not be binding.

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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.
Standard Provisions		
Grace Period	§ 38.2-3527	Each policy 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.
Incontestability	§ 38.2-3528	Each policy shall contain a provision that the validity of the policy shall not be contested after it has been in force for 2 years from date of issue, except for non-payment of premiums. No statement made by the person shall be used in contesting the validity after the insurance has been in force prior to the contest for a period of 2 years and unless the statement is contained in a written statement signed by him.
Entire Contract	§ 38.2-3529	Each policy shall contain a provision that the policy, any application of the policyowner, and any individual applications of the persons insured shall constitute the entire contract between the parties. It shall state that a copy of the application of the policyowner shall be attached to policy when issued, that all statements made by the policyowner and insureds shall be deemed representations and not warranties and that no written statement made by any person insured shall be used in any contest unless a copy of the statement is furnished to the person, his beneficiary or personal representative.
Evidence of Insurability	§ 38.2-3530	Each policy shall contain a provision setting forth any conditions under which the insurer reserves the right to require a person eligible for insurance to furnish evidence of individual insurability.
Misstatement of Age	§ 38.2-3532	Each policy shall contain a provision that an equitable adjustment of premiums, benefits, or both, shall be made if the age of a person insured has been misstated.
Individual Certificates	§ 38.2-3533	Each policy shall contain a provision that the insurer will issue to the policyholder for delivery to each person insured a certificate of insurance.
Notice of Claim	§ 38.2-3534	Each policy shall contain a provision that written notice of a claim shall be given to the insurer within 20 days after the occurrence or commencement of any loss covered by the policy.
Claim Forms	§ 38.2-3535	Each policy shall contain a provision that the insurer shall furnish forms for filing proof of loss within 15 days after the insurer has received notice of any claim.

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Proof of Loss	§ 38.2-3536	Each policy shall contain a provision that written proof of loss shall be furnished to the insurer within 90 days after the date of loss.
Time of Payment of Claims	§ 38.2-3537	Each policy shall contain a provision that all benefits payable under the policy other than benefits for a loss of time shall be payable within 60 days after receipt of proof of loss.
Payment of Benefits	§ 38.2-3538	Each policy shall contain a provision that benefits for loss of life of the person insured shall be payable to the beneficiary designated by the person insured. If policy contains family status conditions, beneficiary may be the family member specified by the policy.
Physical Examinations/Autopsy	§ 38.2-3539	Each policy shall contain a provision that the insurer shall have the right to examine the person for whom a claim is made, when and as often as it may reasonably require during the pendency of the claim or make an autopsy where it is not prohibited by law.
Legal Actions	§ 38.2-3540	Each policy shall contain a provision that no action at law or in equity shall be brought to recover on a policy within 60 days after proof of loss has been filed in accordance with policy requirements and that no such action shall be brought after the expiration of 3 years from the time that proof of loss was required to be filed.
Claims Experience	§ 38.2-3540.1	Each policy shall contain a provision that a complete record of the policyholders' claims experience shall be provided, upon request. This record shall be made available not less than 30 days prior to the date upon which premiums or contractual terms of policy may be amended.
Termination Notice	§ 38.2-3542 C	Written notice of termination must be given to certain employers prior to termination of coverage.
Minimum Anticipated Loss Ratio	§ 38.2-3601 14VAC5-170-120 A 1 a	Group Medicare supplement policies are expected to return to policyholders in the form of aggregate benefits at least 75% of aggregate premiums collected.
Free Look Notice	§ 38.2-3604	30-day free look period required.
Definitions and Terms	14VAC5-170-30 14VAC5-170-40	Certain terms used in policy must be defined. "Medicare" shall be defined in the policy and certificate.
General Provisions		
Policy not more restrictive than Medicare	14VAC5-170-50 A	No policy may be advertised, solicited or issued for delivery if the policy or certificate contains exclusions or limitations more restrictive than Medicare.
No Waiver to exclude Pre-Existing Conditions	14VAC5-170-50 B	No Medicare supplement policy may use waivers to exclude, limit or reduce coverage or benefits.
No Duplication of Medicare Benefits	14VAC5-170-50 C	No Medicare supplement policy shall contain benefits that duplicate Medicare benefits.
Accident & Sickness Benefits – Same	14VAC5-170-75 B 2	Policy shall not indemnify against losses from sickness on a different basis than losses from accidents.

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Medicare Changes Policy Automatically changes	14VAC5-170-75 B 3	Benefits designed to cover cost sharing amounts under Medicare will automatically change to coincide with any changes to Medicare deductibles and copayment percentage factors. Premiums may be modified to correspond with such changes if loss ratios have been met.
Spouse – Insured upon term. of insured	14VAC5-170-75 B 4	Policy shall not provide for termination of coverage of spouse solely because of the occurrence of an event specified for termination of the insured, except non-payment of premiums.
Extension of Benefits	14VAC5-170-75 B 6	Termination of a Medicare supplement policy shall be without prejudice to any continuous loss that commenced while the policy was in force.
Suspension of Coverage	14VAC5-170-75 B 7 a 14VAC5-170-75 B 7 b 14VAC5-170-75 B 7 d	Medicaid eligibility.
	15 VAC 5-170-75 B 7 c 14VAC5-170-75 B 7 d	Loss of coverage under group health plan defined in the Social Security Act.
Core Benefits	14VAC5-170-75 C	Standards for core benefits common to all Medicare supplement insurance benefit plans.
Standards for Plans B, C, D, F High Deductible F, G, M, N	14VAC5-170-75 D	This section provides benefits required for each type plan issued. See section of code for benefit standards for each plan under 14VAC5-170-85.
Make Available Basic Core Benefits	14VAC5-170-85 B 1	Every insurer shall make available basic "core" package as defined in 14VAC5-170-75 C.
Additional Benefits for Plans K, L	14VAC5-170-85 B 2	Refer to 14VAC5-170-85 F 8 and F 9.
Designation of Plan	14VAC5-170-85 D	Plans shall be uniform in structure, language, designation and format to the Plans A – L listed in this subsection.
One Form of a Policy or Certificate for Each Plan Type	14VAC5-170-130 C	See regulation for exceptions.
Riders – Signed Acceptance	14VAC5-170-150 A 2	All riders added after date of issue which reduce or eliminate benefits shall require a signed acceptance by the insured.
No Policy Benefits Based on UCR	14VAC5-170-150 A 3	Medicare supplement policies shall not pay benefits based on "usual and customary" or "reasonable and customary" or words of similar import.
Receipt of Buyers Guide	14VAC5-170-150 A 6	Issuers shall provide to Medicare eligible person a Guide to Health Insurance for People with Medicare upon application and acknowledgement of receipt shall be obtained by issuer.
Pre-Existing Conditions		
Pre-Existing Conditions Definition	14VAC5-170-75 B 1	Pre-Existing Definition – 6 months, Pre-existing limitation – 6 months
Pre-Existing Limitation Separate Paragraph	14VAC5-170-150 A 4	Pre-existing condition limitations shall appear as a separate paragraph in certificate and be labeled as such.

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Pre-Existing Conditions – 63 Days Creditable Coverage	Administrative Letter 1998-9	Medicare supplement policy applicants that apply not later than 63 days after termination of enrollment and who submit evidence of date of termination with the application are eligible persons. With respect to eligible persons, an issuer shall not: 1) Deny or condition the issuance of a policy offered and available for issue to new enrollees. 2) Discriminate in pricing of the policy because of health status, claims experience, receipt of health care, or medical condition, or 3) Impose an exclusion of benefits based upon pre-existing conditions. If period of credible coverage is less than six months, the pre-existing condition period may be reduced by the aggregate of the period of creditable coverage.
Eligibility Provisions		
Open Enrollment Guaranteed Issue – Pre-Existing – 6 months Allowed	14VAC5-170-100 A	Issuer may not deny Medicare supplement coverage nor discriminate in the pricing of such policy because of health status, claims experience, receipt of health care or medical condition of applicant submitting prior to the 6 month period when individual is both 65 or older and enrolled under Medicare Part B. All plans currently available will be made available to those who qualify regardless of age.
Renewability Provisions		
Guaranteed Renewable Policy Terminated by Policyholder and Not Replaced	14VAC5-170-75 B 5	Each Medicare supplement policy shall be guaranteed renewable and the issuer shall not cancel or non-renew solely for health status. Issuer shall not cancel or non-renew for any reason except nonpayment of premiums or material misrepresentation. If the Medicare supplement policy is terminated by the group policyholder and not replaced, an individual Medicare supplement policy must be offered to the certificateholders. If the certificateholder terminates membership in the group, an individual conversion policy must be offered or at the option of the group policyholder, continuation of coverage under the group policy.
Renewal Clause – Captioned on first page of policy. Attained Age Disclosure	14VAC5-170-150 A 1	Renewability provision shall be appropriately captioned and shall appear on the first page of the certificate with any reservation of the right to change premiums and any automatic renewal increase based on policyholders age. Attained Age Disclosure in at least 14-point type.
Replacement Provisions		
Outline of Coverage Provision	14VAC5-170-150 D	All outlines of coverage shall be in essentially the same format as shown in this section.
Replacement notice required when replacing Medicare supplement coverage	14VAC5-170-160 D	Upon replacement of Medicare supplement certificate, issuer must provide replacement notice to applicant. One copy of replacement notice shall remain on file with the issuer.

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Notice to Buyer prominent on first page of certificate	14VAC5-170-180 A 3	Notice to Buyer must appear prominently on first page of certificate.
Replacing Certificates – No Pre-ex or waiting periods greater than remaining on old policy	14VAC5-170-210	When replacing certificates – Issuer will waive all time periods applicable to pre-existing conditions, waiting periods, elimination periods and probationary periods to the extent such time was spent under the original policy. If certificate is over 6 months old, replacing certificate shall not have a preexisting condition limitation or exclusion.
Rates		
	14VAC5-170-130 B	Rate filing and actuarial memorandum.

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

The Forms and Rates Section of the Life and Health Division reviews group Medicare supplement insurance. Please contact this section at (804) 371-9110 if you have questions or need additional information about this line of insurance.

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I hereby certify that I have reviewed the attached group Medicare supplement filing and determined that it is in compliance with the group Medicare supplement checklist.

Signed: ____

Name (please print): ___________________________________

Company Name: ____

Date: _______________ Phone No: ( ) __________________ FAX No: ( )_________________

E-Mail Address: ______________________________________