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

REVIEW REQUIREMENTS	REFERENCES	COMMENTS
Filing Requirements		
Transmittal Letter	14VAC5-100-40	**For Paper Filings:** Must be submitted in duplicate 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 modification of previously approved forms and set forth the exact changes that are intended.
	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 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 envelope is required. The letter of transmittal must be addressed to: State Corporation Commission, Bureau of Insurance, P. O. Box 1157, Richmond, VA 23218
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.
		(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.

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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).
	Admin Letter 1983-7	Transmittal letter must include the name and the NAIC number of the company for which filing is made.
Forms		
Form Number	14VAC5-100-50 1	Form number must appear in the lower left-hand corner of the first page of the form.
Full & Proper Corp. Name	14VAC5-100-50 2	Full and proper corporate name (including Inc.) must prominently appear on first page or cover sheet of all forms.
Final Form to be used	14VAC5-100-50 3	Form must be submitted in final form and "John Doe" format.
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 application was previously approved, advise date of approval).
Type Size	14VAC5-100-50 5 14VAC5-110-50 C	Individual accident and sickness forms must be printed with type size of at least 10-point type. All other forms must be printed with type size of at least eight-point.
Readable Policy Requirements	14VAC5-110-50 A	Readable policy must be a precise and accurate legal contract in form and appearance.
Table of Contents	14VAC5-110-50 B	Required for policy of more than 3 pages.
Type Size	14VAC5-110-50 C	Type size must be at least 10-point type.
Flesch Score	14VAC5-110-50 D	Flesch score reading of 40 or more.
Readability	14VAC5-110-60	Readability certification is required. Must disclose the score, number of words, sentences, and syllables for each form
Contents of Policy	§ 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.
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.
Required Provisions		
Entire Considerations/ Premium	§ 38.2-3500 A 1	The entire consideration must be expressed in the policy.
Effective – Terminates	§ 38.2-3500 A 2	The time (i.e. 12 PM on effective date) at which the policy takes effect and terminates must be stated in the policy.
Exceptions – Reductions	§ 38.2-3500 A 4	Exceptions and Reductions must appear in the policy with the benefit or in an appropriate captioned section. If exception/reduction applies only to single benefit, then it must appear with that benefit.
DMAS Payor of Last Resort	§ 38.2-3500 A 7	Policy must contain statement regarding the status of the Department of Medical Assistance Services as the payor of last resort.
Notice of Policy	§ 38.2-3502	Each policy must contain a notice on first page stating substantially the wording in this section. If parts of notice inapplicable, it may be modified with the Commission's approval.
Entire Contract/Changes	§ 38.2-3503 A 1	Provision that this policy, including the amendment and attached papers, if any, constitute the entire contract of insurance. No change is valid unless approved by Company executive officer, endorsed hereon or attached hereto. No agent may change or waive any of the policy's provisions.
Time Limit on Certain Defenses/Incontestability	§ 38.2-3503 A 2 A 2 a	TLCD – Only fraudulent misstatements may be used after 2 years to deny a claim or void the policy. Incontestable – After 2 years from issue during insured's lifetime, the Company cannot contest the statements in application. Pre-Existing conditions cannot be greater than 6 months for Medicare supplement policies (See 14VAC5-170-75.B 1).
Grace Period	§ 38.2-3503 A 3	Grace period provision must state this policy has a 31-day grace period. During the grace period the policy shall stay in force.
Reinstatement	§ 38.2-3503 A 4	If renewal premium not received within grace period, policy will lapse. Insured may apply for reinstatement, if accepted insurance starts on approval date. If no disapproval received by 45th day insurance is effective on the 45th day after conditional receipt of premium. Reinstatement will cover only loss from injury after approval date and sickness starting more than 10 days after such date.

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Notice of Claim (20 Days)	§ 38.2-3503 A 5	Notice of claim must be given to Company within 20 days after covered loss starts or as soon as reasonably possible. Notice shall include name of Insured and/or Claimant, and the policy number.
Claim Forms (15 Days)	§ 38.2-3503 A 6	Company must provide Claimant with claim forms within 15 days. If not, proof of loss requirements can be met by giving the Company a written statement of the nature and extent of the loss within 90 days.
Proof of Loss (90 Days)	§ 38.2-3503 A 7	Written proof of loss must be given within 90 days to the Company. If not reasonable possible to give proof of loss in the time provided company shall not reduce nor deny claim if proof is filed as soon as reasonably possible. In any event, except in the absence of legal capacity proof must be given no later than 1 year from the time specified.
Time of Payment of Claims	§ 38.2-3503 A 8	After receiving written proof of loss, Company will pay monthly all benefits then due. Benefits for any other loss will be paid as soon as proper written proof is received.
Payment of Claims	§ 38.2-3503 A 9	Benefits will be paid to the Insured if living, otherwise to the beneficiary or the Insured's estate. If paid to the Insured's estate or beneficiary the amount shall not exceed $2,000.
Physical Examinations and Autopsy	§ 38.2-3503 A 10	The Company, at its own expense, can have the Insured examined as often as reasonably possible while claim is pending. It may also have autopsy made unless prohibited by law.
Legal Actions	§ 38.2-3503 A 11	No legal action may be brought within 60 days after written proof of loss has been given. No legal action may be brought after 3 years from the time written proof of loss is required to be given.
Change of Beneficiary	§ 38.2-3503 A 12	Insured may change beneficiary at any time except beneficiary's consent is required if designated as irrevocable beneficiary.
Cancellation by Insured	§ 38.2-3503 A 13	Insured may cancel this policy at any time by written notice to the company. In the event of cancellation, the company shall promptly return the unearned portion of any premium; the earned premium shall be computed pro-rata. Cancellation shall be without prejudice to any claim originating prior to the effective date of cancellation.
Individual Anticipated Loss Ratio	§ 38.2-3603 14VAC5-170-120 A 1 b	Individual Medicare supplement policies are expected to return to policyholders in the form of aggregate benefits at least 65% of aggregate premiums collected.
Other Provisions		
Misstatement of Age	§ 38.2-3504 2	If Insured's age has been misstated, benefits will be those that the premium paid would have purchased at the correct age.
Other Insurance in this Company	§ 38.2-3504 3	If Insured has more than one policy with Insurer, Insured may keep the one policy selected and Company will return all premiums paid for other such policies.

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REVIEW REQUIREMENTS	REFERENCES	COMMENTS
Insurance with Other Companies	§ 38.2-3504 4	If there is other valid coverage providing benefits for the same loss on a provision of service basis or on an expense incurred basis and of which the company has not been given written notice prior to the occurrence or commencement of loss, the only liability under any expense incurred coverage of this policy shall be for such proportion of the loss as the amount which would otherwise have been payable under the policy plus the total of the like amounts under all such other valid coverages for the same loss of which this company had notice bears to the total like amounts under all valid coverages for such loss.
Insurance with Other Companies	§ 38.2-3504 5	If there is other valid coverage providing benefits for the same loss on other than an expense incurred basis and of which this Company has not been given written notice prior to the occurrence or commencement of loss, the only liability for such benefits under this policy shall be for such proportion of the indemnities otherwise provided under this policy for such loss as the like indemnities of which the company has notice.
Unpaid Premium	38.2-3504 7	When a claim is paid, any premium due and unpaid may be deducted from the claim payment.
Conformity with State Statutes	§ 38.2-3504 9	Any provision of this policy that on its effective date is in conflict with the laws of the state in which the Insured resides on that date is hereby amended to conform to the minimum requirement of the law.
Free Look Notice Required	§ 38.2-3604	A 30-day (minimum) right to return provision must appear on the first page of the policy.
Definitions and Terms	14VAC5-170-30 & 40	Certain terms used in the policy must be defined.
Medicare Definition	14VAC5-170-40	“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.
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 difference basis than losses from accidents.
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 a spouse solely because of the occurrence of an event specified for termination of the insured, except non-payment of premiums.

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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.
	14VAC5-170-75 B 7 c 14VAC5-170-75 B 7 d	Loss of coverage under group health plan defined in the Social Security Act.
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 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.
One Form of a Policy for Each Plan Type	14VAC 5-170-130 C	See regulation for exceptions.
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 policy and be labeled as such.
Pre-Existing Conditions – 63 Days credible coverage	Administrative Letter 1998-9	Medicare supplement policy applicants that apply no 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 credible coverage.

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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 which individual is both 65 or older and enrolled under Medicare Part B. All plans will be made available to those who qualify regardless of age.
Renewability Provisions		
Guaranteed Renewability	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 for nonpayment of premiums or material representation.
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 policy, and include 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		
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.
Outline of Coverage Provision	14VAC5-170-150 D	All outlines shall be in essentially the same format as shown in this section.
Replacement notice required when replacing Medicare Supplement Policies	14VAC5-170-160 D	Upon replacement of Medicare supplement policy, issuer must provide replacement notice to applicant. One copy of replacement notice shall remain on file with the issuer.
Notice to Buyer Prominent on First Page of Policy	14VAC5-170-180 A 3	Notice to Buyer must appear prominently on first page of policy.
Replacing policies – no pre-ex or waiting periods greater than remaining on old policy	14VAC5-170-210	When replacing policies – 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 policy is over 6 months old, replacing policy shall not provide any time periods.
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 individual Medicare supplement insurance. Please contact this section at (804) 371-9741 if you have questions or need additional information about this line of insurance.

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

Signed: _____

Name (please print): _____

Company Name: _____

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

E-Mail Address: _____