Print Reset Form

Review Requirements Checklist
INDIVIDUAL MEDICARE SELECT INSURANCE

NOTICE: This checklist must be completed in its entirety and included with each submitted form. Failure to provide a completed checklist will result in a delay of the review of the submission and may result in rejection of the filing.

This document is intended to assist carriers in preparing form filings for approval by the Bureau of Insurance. It provides guidance based on current Virginia laws and regulations. It should be noted, however, that this checklist should not be used exclusive of other important resources, including, but not limited to, any and all other applicable state insurance laws and associated rules and regulations. It is the responsibility of the carriers to verify that submitted forms comply with all relevant statutory and regulatory requirements. Note that some regulatory references in the comments column are paraphrased. Please review the applicable citation for the full text of the requirement.

You can find out more about related laws, rules and orders from the Administration of Insurance Regulation section of our site.

The Forms and Rates Section of the Life and Health Division will review submissions based on the requirements noted in this checklist. Please contact this Section at (804) 371-9532 if you have questions or need additional information about these requirements.

Company Name:
Third Party Filer:
SERFF Tracking Number:
Form Number:

REVIEW REQUIREMENTS	REFERENCES	COMMENTS	PG #
General Filing Requirements			
Source of Filing	14 VAC 5-101-40	Filings shall be submitted in SERFF or submitted in writing to the Commission. If being filed by a third party, filing authorization must be included.	
Filing Description	14 VAC 5-101-50 C 1	Filing description must include the type of insurance form, including a description of the form and the market for which the form is intended; intentions to concentrate on a specialized market should be noted.	
	14 VAC 5-101-50 C 2	Filing description must include the form number of each form that is being filed.	
	14 VAC 5-101-50 C 3	Filing description must state whether submitted form is new, or if replacing, revising, or modifying a previously approved form and the exact changes that are intended.	
	14 VAC 5-101-50 C 4	Filing description must identify any change in benefits and indicate whether the change affects premium rates for the form.	
	14 VAC 5-101-50 C 5	Filing description must state if approval of a form submitted has been withdrawn by another regulatory body and the reasons for such a withdrawal.	
	14 VAC 5-101-50 F	Any form filed that is to be used with a previously approved form, including an application, shall identify the form number, approval date, and SERFF or state tracking number in the new filing.	
	14 VAC 5-101-50 G	Any amendment, endorsement, or rider that intends to revise a previously approved form shall be accompanied by the previously approved form filed as supporting documentation.	
HELP TIP:		If a form filing is submitted as new in Virginia, but was previously disapproved, withdrawn, or rejected in Virginia, please provide details such as the SERFF or State tracking information, form number, and the date that the form filing was disapproved, withdrawn, or rejected if available.	
Forms			
Form Number	14 VAC 5-101-60 1	Form Number must appear in the lower left-hand corner of the first page of the form. It shall consist of numbers, letters, or a combination of both. The form number shall distinguish the form from all other forms used by the company.	
Company Name and Address	14 VAC 5-101-60 2	The full licensed name of the company, including the address of the home office, shall appear in prominent print at the top of the cover page of any policy, application, or enrollment form. The full licensed name of the company shall appear in prominent print on all other forms.	
Marketing Name or Logo	14 VAC 5-101-60 3	A marketing name or logo also may be used on the form, provided that the marketing name or logo does not mislead as to the identity of the filing company.	

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	14 VAC 5-101-60 4	The cover page of a policy also shall include the address of an office that will administer the policy, if different from the home office, a company telephone number, and company website address.	
Final Form – John Doe	14 VAC 5-101-60 5	Form must be submitted in "final form" and in "John Doe fashion" to indicate its intended use.	
Electronic Version	14 VAC 5-101-60 6	Each form that is to be used in an electronic version shall be filed in a format that matches the electronic version exactly.	
Readability	14 VAC 5-101-70 A	Each form submitted for review or approval shall be written in simplified language, logically and clearly arranged, printed in a legible format and understandable to a person of average intelligence without special insurance knowledge or training.	
	14 VAC 5-101-70 B	A policy of more than three pages shall include a table of contents listing the principal sections and provisions and the pages on which they are found.	
	14 VAC 5-101-70 C	Defined words and terms shall be placed in a separate definition section that is clearly identified, unless only used in one section.	
	14 VAC 5-101-70 D	A policy shall be divided into logically arranged sections with an appropriately named caption or heading for ease in locating desired content. Captions and headings shall be clearly set apart from the general text.	
	14 VAC 5-101-70 E	Any form submitted for review or approval shall be printed in at least 10-point type size.	
	14 VAC 5-101-70 F	Any policy shall achieve a minimum Flesch reading ease score of 50 or an equivalent score using another comparable test, unless otherwise specified by statute, or an exception requested pursuant to 14 VAC 5-101-70 G.	
Variability	14 VAC 5-101-80	Use of variable bracketed information shall be limited. Use of brackets within brackets is not permitted. Each instance of variable text shall appear in brackets on a form and shall be separately and completely explained in detail in a Statement of Variability document. Each explanation of variability shall appear in the same order that it appears on the form. Additional guidance is attached to SERFF General Instructions.	
Certificate of Compliance	14 VAC 5-101-110	Each form filing shall contain a Certificate of Compliance signed by an officer of the company certifying the Flesch reading ease score of at least 50; that a review of the form has been conducted and is consistent and complies with the requirements of Title 38.2 and applicable rules and regulations; and a statement that failure to comply with these requirements will result in disapproval of the filing.	

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Required Provisions			
Contents of Policy	§ 38.2-305 A	Parties to policy named; subject of insurance; risks insured against; time insurance takes effect; statement of premium.	
Entire Considerations/ Premium	§ 38.2-3500 A	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	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 14VAC5-170-70 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 or 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 Claim	§ 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 Claim	§ 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 & 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.	

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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.	
Indiv. Anticipated Loss Ratio	§ 38.2-3603	Individual Medicare supplement policies are expected to return to policyholders in the form of aggregate benefits at least 65% of aggregate premiums collected.	
Free Look Notice Required	§ 38.2-3604	A 30-day (minimum) right to return provision must appear on the first page of the policy.	
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 with Insurer	§ 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.	
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.	
Intoxicants and Narcotics	§ 38.2-3504 11	Company will not be liable for any loss resulting from the Insured's being drunk, or under the influence of any narcotic unless taken on the advice of a physician.	
Definitions	14 VAC 5-170-30 & 40	Definitions used in policy.	
Medicare Definition	14 VAC 5-170-40	"Medicare" shall be defined in the policy and certificate.	
General Provisions			
Policy not more restrictive than Medicare	14 VAC 5-170-50 A	No policy may be advertised, solicited or issued for delivery if the policy or certificate contains exclusions or limitations more restrictive than Medicare.	

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No Waiver to Exclude Pre-Existing Conditions	1 4VAC 5-170-50 B	No Medicare supplement policy may use waivers to exclude, limit or reduce coverage.	
No Duplication of Medicare Benefits	14 VAC 5-170-50 C	No Medicare supplement policy shall contain benefits that duplicate Medicare benefits.	
Standards for Plans B, C, D, F, High Deductible F, G, M, N	14 VAC 5-170-70 D	This section provides benefits required for each type plan issued. See section of code for benefit standards for each plan.	
Accident & Sickness Benefits - Same	14 VAC 5-170-75 B 2	Policy shall not indemnify against losses from sickness on a difference basis than losses from accidents.	
Medicare Changes Policy Automatically Changes	14 VAC 5-170-75 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	14 VAC 5-170-75 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.	
Make available Basic Package A	14 VAC 5-170-85 B 1	Every insurer shall make available basic “core” package as defined in 14VAC5-170-75 C.	
Additional Benefits Plans K and L	14 VAC 5-170-85 B 2	Refer to 14VAC5-170-85 F 8 and F 9.	
Designation of Plan	14 VAC 5-170-85 D	Plans shall be uniform in structure, language, designation and format to the plans C & D, and K & L listed in this subsection.	
Medicare Select Requirements	14 VAC 5-170-90		
Receipt of Buyers Guide	14 VAC 5-170-150 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.	
Prospective Payment System for Hospital OP Services	Administrative Letter 2000-9	Coinsurance for hospital outpatient department services will be based on an established fixed co-payment amount for the particular service provided.	
Pre-Existing Conditions			
Pre-Existing Conditions Definition	14 VAC 5-170-75 B 1	Pre-Existing Definition – 6 months Pre-Existing Limitation – 6 months.	
Pre-Existing Limitation Separate Paragraph	14 VAC 5-170-150 A 4	Pre-Existing condition limitations shall appear as a separate paragraph in policy and be labeled as such.	

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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 6 months, the pre-existing condition period may be reduced by the aggregate of the period of credible coverage.	
Eligibility Provisions			
Open Enrollment Guaranteed Issue – Pre-Existing – 6 Months Allowed	14 VAC 5-170-100 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 in 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			
Med supp shall be GR no Cancel except non-payment or material Misrepresentation	14 VAC 5-170-75 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 misrepresentation.	
Renewal Clause – Captioned on first page of policy	14 VAC 5-170-150 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.	
Replacement Provisions			
Managed Care Health Insurance Plans (MCHIPS)	§ 38.2-5800		
	§ 38.2-5803	Disclosures and representations to enrollees.	
Riders – Signed Acceptance	14 VAC 5-170-150 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	14 VAC 5-170-150 A 3	Medicare supplement policies shall not pay benefits based on “usual and customary” or “reasonable and customary” or words of similar import.	

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Outline of Coverage provision	14 VAC 5-170-150 C	All outlines of coverage shall be in essentially the same format as shown in this section.	
Replacement notice required when replacing Medicare supplement policies	14 VAC 5-170-160 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	14 VAC 5-170-180 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	14 VAC 5-170-210	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			
	14 VAC 5-170-130 B	Rate filing and actuarial memorandum.	

Review Requirements Checklist
INDIVIDUAL MEDICARE SELECT INSURANCE

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

Signed: _____

Name (please print): _____

Company Name: _____

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

E-Mail Address: _____