Review Requirements Checklist
GROUP ACCIDENT AND SICKNESS
ESSENTIAL AND STANDARD PLANS – PREFERRED PROVIDER COVERAGE
(See Separate Federal Market Reform Healthcare Act Checklist When Applicable)

REVIEW REQUIREMENTS	REFERENCES	COMMENTS
General Filing Requirements		
Transmittal Letter	14 VAC 5-100-40	**For Paper Filings:** Must be submitted in duplicate for each filing, describing each form, its intended use and kind of insurance provided.
	14 VAC 5-100-40 1	Forms submitted and described in transmittal letter must have a number that consists of digits, letters or a combination of both.
	14 VAC 5-100-40 2	Must clearly indicate if forms are replacements, revisions, or modifications of previously approved forms and describe the exact changes that are intended.
	14 VAC 5-100-40 3	Certification of Compliance signed by General Counsel or officer of company or attorney or actuary representing company is required.
	14 VAC 5-100-40 5	Description of market for which form is intended.
	14 VAC 5-100-40 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.
Forms		
Form Number	14 VAC 5-100-50 1	Form number must appear in lower left-hand corner of first page of each form.
Company name & address	14 VAC 5-100-50 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	14 VAC 5-100-50 3	Form must be submitted in the form in which it will be issued and completed in "John Doe" fashion to indicate its intended use.
Application	14 VAC 5-100-50 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	14 VAC 5-100-50 5	Individual Accident and Sickness forms must be printed with type size of at least ten-point type. All other forms must be printed with type size of at least eight-point.
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 Insurance Code does not define "Insurance Fraud." Any notice regarding insurance fraud is in non-compliance with this section of the Code. Variations in a notice warning of consequences of making fraudulent statements are acceptable. The notice may disclose that it does not apply to Virginia or may disclose states where applicable.
Other Filing Requirements		
Utilization Review	§ 32.1-137.9 F	The evidence of coverage must contain a complete summary of process for reconsideration of adverse decisions, and process for appeal.
Contents of Policies/Important Notice	§ 38.2-305	Each policy shall specify: (1) names of parties to contract, (2) subject of insurance, (3) risk insured against, (4) time the insurance takes effect and period during which insurance is to continue, (5) conditions pertaining to insurance. Policy must also contain an important notice regarding who to contact with questions.
Rate Filing	§ 38.2-316 A	Requires that rates be filed with the Commission prior to use in the Commonwealth of Virginia.
Unfair Discrimination	§ 38.2-508	No person shall discriminate between individuals of the same class in the amount of premium, policy fees or rates charged for any policy. Cannot refuse to insure, refuse to continue to insure or limit coverage because of blindness, or partial blindness, mental or physical impairments. Cannot unfairly discriminate by refusing to issue, renew, cancel or limit amount of coverage solely because of geographic location.
Medicaid Eligibility	§ 38.2-508.3	Medicaid shall not be considered in determining coverage eligibility or benefits payable.
Subrogation	§ 38.2-3405 A	No insurance contract shall contain any provision providing for subrogation of any person's right to recovery for person injuries from a third person.
COB/Liability Coverage Prohibited	§ 38.2-3405 B	No contract shall contain provisions requiring a beneficiary to sign any agreement regarding proceeds of a recovery. COB provisions may not operate to reduce benefits because of benefits provided by liability insurance or related medical expenses.
Worker's Comp. Exclusion	§ 38.2-3405 C	The issuer shall not exclude coverage for any medical condition whenever benefits payable under workers' compensation are excluded from coverage.
Claims Paid to Insureds for Services from Nonpar. Physicians	§ 38.2-3407.13:2	The certificate and explanation of benefit must include notice for the enrollees, for services performed by a non-participating provider, informing the enrollee of his or her responsibility to apply the plan payment to the claim from such non-participating provider.
Renewability	§ 38.2-3432.1 A	Each insurer shall renew or continue in force coverage with respect to all insureds at the option of the employer with numerous exceptions listed in this section of the Code.

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Pre-Existing Definition	§ 38.2-3432.3 A 1	Each policy shall contain a definition of a pre-existing exclusion that relates to a condition regardless of the cause of the condition for which medical advice, diagnosis, care, or treatment was recommended or received within the 6-month period ending on the enrollment date.
Pre-Existing Exclusion	§ 38.2-3432.3 A 3 & B	Such exclusion extends for a period of not more than 12 months after the enrollment date; however a health insurer may not impose any pre-existing condition exclusion for an individual who, as of the last day of the 30-day period beginning with the date of birth, is covered under credible coverage.
Credible Coverage Period	§ 38.2-3432.3 C	A period of credible coverage shall not be counted if, after such period and before the enrollment date, there was a 63-day period during all of which the individual was not covered under any credible coverage.
Late Enrollee	§ 38.2-3432.3 A 3 & N	A late enrollee may be excluded from coverage for up to 12 months or may have a pre-existing condition limitation apply for up to 12 months; however, no enrollee shall be excluded from some or all coverage for more than 12 months.
Eligibility to Enroll	§ 38.2-3436	Any insurer offering group health coverage may not establish rules for eligibility of any individual to enroll under the terms of the plan based on any health status-related factors.
Group A&S Definitions	§ 38.2-3521.1	This section provides that no policy or group accident and sickness insurance shall be delivered in this Commonwealth unless it conforms to one of the listed definitions.
Non-Defined Groups	§ 38.2-3522.1	Group A&S insurance offered to a resident of this Commonwealth under a policy issued to a group other than one described in Section 38.2-3521.1 shall be subject to certain requirements for policies issued in Virginia or in other states.
Policies Issued Outside of Virginia	§ 38.2-3523.2	Policies issued outside of this Commonwealth, providing coverage to residents of this Commonwealth, that do not qualify under Sections 38.2-3521.1 or 38.2-3522.1 shall be subject to the statutory requirements of this title.
Dependent Coverage	§ 38.2-3525	Coverage may be extended to insure the spouse, child, and any other class of persons as may mutually be agreed upon by the insurer and the group policyholder.
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.

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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. 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.
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.
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. All other benefits shall be payable to the insured.
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.

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Legal Actions	§ 38.2-3540	Each policy shall contain a provision that the 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 (Applies to employer groups only)	§ 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.
Conversion	§ 38.2-3541	Each policy shall contain a provision that sets forth two options regarding conversion or continuation of insurance.
Termination Notice	§ 38.2-3542 C	Written notice of termination must be given to certain employers prior to termination of coverage.
Standard Provisions		
Definitions	14 VAC 5-234-30	Certain terms when used must be defined as set forth in this section.
Elimination Riders not Allowed	14 VAC 5-234-40 D	Riders or endorsements may not be issued which reduce or eliminate benefits, with exception of dental benefits.
Optional Dental Benefits	14 VAC 5-234-40 I	Carrier must offer benefit coverage that does not provide dental benefits.
Minimum Standards for Essential Benefit Plan	14 VAC 5-234-50	Plan must include minimum standards for benefits for the Essential Benefit Plan. Plan may not include mandated benefits provided under § 38.2-3408 through § 38.2-3418.13.
Minimum Standards for Standard Benefit Plan	14 VAC 5-234-60	Plan must include minimum standards for benefits for the Standard Benefit Plan. Plan may not include mandated benefits provided under § 38.2-3408 through § 38.2-3418.13.
Limitations and Exclusions	14 VAC 5-234-70 A	Plan may not limit or exclude coverage by type of illness, accident, treatment or medical treatment, except for those stated in this regulation.
No Waiver for Preexisting Conditions	14 VAC 5-234-70 B	Waivers are not allowed to exclude, limit or reduce coverage or benefits for preexisting conditions.
Cost Sharing Requirements	14 VAC 5-234-80 2 a, 1, 2 and 2 b	Employees may not be held responsible for amounts in excess of those stated in this regulation.
Out of Pocket Limits	14 VAC 5-234-80 2 c	For employees with individual coverage combined in-network and out-of-network out of pocket limit may not exceed $5,000 per contract or calendar year. For employees with other than individual coverage, out of pocket limit may not exceed $15,000 per contract or calendar year.

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Lifetime Maximum Amount	14 VAC 5-234-80 2 d	Plan may have a minimum lifetime maximum of $1 million per covered person in-network and $250,000 per person out-of-network
Benefit Increases	14 VAC 5-234-90 A	Any rider that increases benefits, with accompanying increase in premium, must be agreed to in writing by contract holder.
Rider Premium	14 VAC 5-234-90 B	When separate premium is charged for benefits provided in connection with rider, such premium must be set forth in the plan.
Preexisting Condition Limitations	14 VAC 5-234-90 C	Plan limitations for preexisting conditions must appear as a separate paragraph entitled, "Preexisting Condition Limitations."
State Corporation Commission Toll Free Number	14 VAC 5-234-90 D	Toll-free number of the SCC's Bureau of Insurance must be included in the plan.
Right to Organization Guidelines	14 VAC 5-234-90 E	Plan must include language advising members of their rights to receive a copy of the current recommendations of the organizations listed in subdivisions 3 or 5 of 14 VAC 5-234-50.
Readability Certification	14 VAC 5-110-60	Required for policies issued to groups with 10 or fewer employees.

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

The Life and Health Division, Forms and Rates Section handles group accident and sickness essential and standard plans for preferred provider coverage. 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 accident and sickness essential and standard plan for preferred provider coverage filing and determined that it is in compliance with the group accident and sickness essential and standard plans for preferred provider coverage checklist.

Signed: _____

Name (please print): _____

Company Name: _____

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

E-Mail Address: _____