Review Requirements Checklist
GROUP MAJOR MEDICAL
(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.
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.

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Other Filing Requirements		
Contents of Policies/Important Notice	§ 38.2-305 B	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 D	The issuer shall not exclude coverage for any medical condition whenever benefits payable under workers' compensation are excluded from coverage.
Basic Health Insurance Coverage (products issued to small employers that exclude one or more state mandated benefits).	§ 38.2-3406.1	The intended purpose of any and all forms developed in accordance with § 38.2 3406.1 must be clearly disclosed when the forms are submitted to the Bureau for approval. Policy forms, subscription contracts, certificate forms or other evidences of coverage furnished to small employers and their employees must prominently disclose any and all state-mandated health benefits that the policy or subscription contract does <u>not</u> provide. (See footnotes below for state-mandated health benefits). Application and enrollment forms must include the following: A prominent disclosure that the policy or contract is not required to provide all state-mandated health benefits, along with the specific state-mandated health benefits that the policy or subscription contract does <u>not</u> provide; and A clear description of any and all eligibility requirements applicable to each employee.

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***Denial of Certain Prescription Drugs	§ 38.2-3407.5	Benefits will not be denied for any drug approved by the FDA for use and treatment of cancer on basis that drug has not been approved by the FDA for the treatment of specific type of cancer for which the drug has been prescribed.
***Prescription Contraceptives	§ 38.2-3407.5:1	Each policy shall offer and make available coverage for any prescribed drug or device approved by the FDA for use as a contraceptive.
***Denial of Benefits for Certain Prescription Drugs	§ 38.2-3407.6:1	Benefits shall not be denied for intractable cancer pain medication based on the fact that dosage is in excess of recommended dosage.
Freedom of Choice for Pharmacies	§ 38.2-3407.7	No preferred provider policy shall prohibit any person from selecting the pharmacy of his choice, whether preferred or non-preferred provider
Ambulance Services	§ 38.2-3407.9 B	If policy provides for ambulance services, any such person shall receive reimbursement for such services directly from the issuer of the policy, when the issuer is presented with an assignment of benefits by the person providing such services.
***Prescription Drug Formularies	§ 38.2-3407.9:01	Policies covering prescription drugs on an outpatient basis may apply a drug formulary.
***Exclusion of Prescription Drug Coverage Prohibited	§ 38.2-3407.9:02	Prescription drugs shall not be excluded from coverage solely on the basis of the length of time since the drug obtained FDA approval.
Terminated PCPs	§ 38.2-3407.10 F	For a period of at least 90 days from date of notice of provider's termination from carrier's provider panel, except when terminated for cause, provider shall be permitted by carrier to render health care services to carrier's enrollees who were in an active course of treatment from provider prior to notice and who requests to continue receiving services of provider. Such providers shall also be permitted to continue rendering services to patients who have entered second trimester of pregnancy or those determined to be terminally ill at the time of provider's termination of participating except when a provider is terminated for cause. At the option of the terminally ill enrollee, coverage may continue for the remainder of the enrollee's life for care directly related to the treatment of the terminal illness.
Reduction of Benefits	§ 38.2-3407.10 M	Carriers shall provide group policyholders written notice of any benefit reductions. Policyholders shall provide employees written notice of benefit reductions.
***Access to Obstetricians/ Gynecologists	§ 38.2-3407.11	Policies that include coverage for obstetrical or gynecological services shall permit any covered female of age thirteen or older direct access, as provided in this section of the Code, to the health care services of a participating obstetrician-gynecologist (i) authorized to provide services under the policy, contract or plan and (ii) selected by such female.
***Access to Specialists; Standing Referrals	§ 38.2-3407.11:1	Each insurer shall permit an individual a standing referral to the health care services of a participating specialist authorized to provide services under such policy and selected by individual, where appropriate.
***Standing Referral for Cancer Patients	§ 38.2-3407.11:2	Procedures shall be in place permitting individuals diagnosed with cancer to have a standing referral to certain physicians.

REVIEW REQUIREMENTS	REFERENCES	COMMENTS
*Breast Cancer Underwriting and Preexisting Conditions Restrictions	§ 38.2-3407.11:3	Plan is prohibited from denying the issuance or renewal of coverage, or from canceling such coverage, or from including the exception or exclusion of benefits based solely on the members having a high risk of breast cancer or having had breast cancer, and having been cancer free for 5 years or more.
Coordination of Benefits: Notice of Primary Coverage	§ 38.2-3407.13:1	COB provision shall be prominent in enrollment materials.
*Obstetrical Care	§ 38.2-3407.16	Obstetrical service benefits shall be no less favorable than for a physical illness generally.
●Reimbursement for Certain Practitioners	§ 38.2-3408	Reimbursement for service that may be legally performed by a person licensed in this Commonwealth shall not be denied because the service is rendered by the licensed practitioner. (See list of practitioners)
Handicapped Children	§ 38.2-3409	Dependent children who are incapable of self-sustaining employment by reason of mental retardation or physical handicap shall be covered beyond the specified age.
*Newborn Child Coverage	§ 38.2-3411	Newborn children shall have identical coverage from moment of birth.
*Child Health Supervision Services (Optional)	§ 38.2-3411.1	Policies shall offer and make available coverage for child health supervision services to provide for periodic examination of covered children.
*Adopted Children	§ 38.2-3411.2	Any insurance benefits applicable for children under the policy shall be payable with respect to adopted children.
*Childhood Immunizations	§ 38.2-3411.3	Policies shall provide coverage for all routine and necessary immunizations for newborn children from birth to 36 months of age.
*Coverage for Infant Hearing Screening and Audiological Examinations	§ 38.2-3411.4	Plan must provide coverage for infant hearing screenings and all necessary audiological examinations pursuant to § 32.1-64.1, using technology approved by the U.S.F.D.A. and, as recommended by the national Joint Committee on Infant Hearing. Coverage must include any follow-up audiological examinations recommended by a physician or audiologist and performed by a licensed audiologist to confirm the existence or absence of hearing loss.
*Mental Health/Substance Abuse	§ 38.2-3412.1 A	Definitions for children, adolescents, adults, treatments, facilities, etc. are provided herein.
*Adult Inpatient	§ 38.2-3412.1 B 1	Coverage for inpatient shall be provided for adults for a minimum period of 20 days per policy or contract year.
*Child/Adolescent Inpatient	§ 38.2-3412.1 B 2	Coverage for inpatient shall be provided for a child or adolescent for a minimum period of 25 days per policy or contract year.
*Partial Hospitalization	§ 38.2-3412.1 B 3	Up to 10 days of inpatient benefits may be converted which shall be no less favorable than an exchange of 1.5 days of partial hospitalization coverage for each inpatient day of coverage.

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*Outpatient Visits	§ 38.2-3412.1 C	A minimum of 20 visits for outpatient treatment for an adult, child or adolescent shall be provided with limits on benefits no more restrictive than limits of benefits applicable to physical illness. Coinsurance factors beyond first 5 visits shall be at least 50%.
*Biologically Based Mental Illness	§ 38.2-3412.1:01	Policies shall provide coverage for biologically based mental illnesses.
Optional Coverage for Obstetrical Services	§ 38.2-3414	Policies shall provide coverage for obstetrical services as an option available to the group policyholder.
*Postpartum Services	§ 38.2-3414.1	Each insurer providing benefits for obstetrical services shall provide coverage for postpartum services as provided herein.
Exclusions/Reductions	§ 38.2-3415	No group policy shall contain any provision excluding or reducing benefits because benefits have been paid or are payable under any individually underwritten and individually issued policy providing exclusively for A&S for which the entire premium is paid by the insured.
*Coverage for Victims of Rape/Incest	§ 38.2-3418	Policies or contracts which provide benefits as a result of an accident shall be construed to include benefits for pregnancy following an act of rate of an insured or subscriber.
●Mammograms	§ 38.2-3418.1	Policies shall provide coverage for low-dose screening mammograms at certain age intervals.
●Pap Smears	§ 38.2-3418.1:2	Each insurer shall provide coverage for annual pap smears for testing performed by any FDA-approved gynecologic cytology screening technologies.
*Bones/Joints	§ 38.2-3418.2	Policies shall not exclude coverage or impose limits involving any bone or joint of the head, neck, face or jaw which are more restrictive than limits applicable to other bones or joints of the skeletal structure based on certain conditions.
*Hemophilia	§ 38.2-3418.3	Insurers shall provide coverage for hemophilia and congenital bleeding disorders.
*Reconstructive Breast Surgery	§ 38.2-3418.4	Insurers shall provide coverage for reconstructive breast surgery coincident with a mastectomy performed for breast cancer or following a mastectomy for breast cancer to reestablish symmetry between the two breasts.
*Early Intervention	§ 38.2-3418.5	Each policy shall provide coverage for medically necessary early intervention services which includes speech and language therapy, occupational therapy, physical therapy and assistive technology services and devices for certain dependents.
*Mastectomy Minimum Hospital Stay	§ 38.2-3418.6	Coverage shall be provided for a minimum inpatient stay of not less than 48 hours following a radical or modified radical mastectomy and not less than 24 hours of inpatient care following a total mastectomy or partial mastectomy with lymph node dissection for the treatment of breast cancer.

REVIEW REQUIREMENTS	REFERENCES	COMMENTS
●PSA Testing	§ 38.2-3418.7	Coverage shall be provided for persons age 50 and over and persons age 40 and over who are at a higher risk for prostate cancer for one PSA test in a 12 month period and digital rectal examinations.
●Colorectal Cancer	§ 38.2-3418.7:1	Each insurer shall provide coverage for colorectal cancer screening, specifically screening with an annual fecal occult blood test, flexible sigmoidoscopy or colonoscopy, or in appropriate circumstances, radiologic imaging.
*Clinical Trials for Cancer	§ 38.2-3418.8	Each insurer shall provide coverage for patient costs incurred during participation in clinical trials for treatment studies on cancer.
*Hysterectomy Minimum Hospital Stay	§ 38.2-3418.9	Each insurer shall provide coverage for laparoscopy-assisted vaginal hysterectomy including a minimum stay in a hospital of not less than 23 hours and coverage for a vaginal hysterectomy including a minimum stay in a hospital of not less than 48 hours as provided in this section
*Diabetes	§ 38.2-3418.10	Each insurer shall provide coverage for diabetes for certain services as provided in this section.
*Hospice Care	§ 38.2-3418.11	Each insurer shall provide coverage for hospice services and shall not prohibit coverage for services when it cannot be demonstrated that the illness is terminal or for individuals with life expectancies of longer than six months.
*Dental Procedures – Hospital Stay/Anesthesia	§ 38.2-3418.12	Insurers shall provide coverage for medically necessary general anesthesia and hospitalization or facility charges of a facility licensed to provide outpatient surgical procedures for certain dental care.
*Morbid Obesity	§ 38.2-3418.13	Policies shall provide coverage for morbid obesity as an option available to the group policyholder through gastric bypass surgery or such other methods.
*Lymphedema	§ 38.2-3418.14	Policies or contracts shall provide coverage for lymphedema.
*Prosthetic Devices and Components	§ 38.2-3418.15	Offer and make available coverage for the health care services for medically necessary prosthetic devices, their repair, fitting, replacement and components.
*Telemedicine Services	§ 38.2-3418.16	Coverage shall be provided for health care services through telemedicine services.
*Coverage for Autism Spectrum Disorder	§ 38.2-3418.17	Coverage and the treatment for the diagnosis of autism spectrum disorder from age two through age six shall be provided, subject to annual maximum benefit limitations set forth in subsection K of this section of the Code. See Code regarding coverage for services beyond age six.
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.
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.
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.
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 § 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 §§ 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.
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.

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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 insured 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.
Add'l. Exclusions/Limitations	§ 38.2-3531	Each policy shall contain a provision specifying all additional exclusions or limitations applicable under the policy for any disease or physical condition of a person which existed prior to the effective date of person's coverage under the policy.
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.
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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REVIEW REQUIREMENTS	REFERENCES	COMMENTS
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	Certain employers shall given written to participating employees in the event of termination or upon the receipt of notice of termination of any such policy not later than 15 days after the termination of a self-insured plan or receipt of the notice of termination.

* = Optional state-mandated health benefits under § 38.2-3406.1
● = Required state-mandated health benefits under § 38.2-3406.1

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 major medical 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 major medical filing and determined that it is in compliance with the group major medical checklist.

Signed: _____

Name (please print): _____

Company Name: _____

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

E-Mail Address: _____