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SENATE BILL NO. 156

AMENDMENT IN THE NATURE OF A SUBSTITUTE

(Proposed by the House Committee on Commerce and Labor on March 2, 2004)

(Patron Prior to Substitute—Senator Potts)

A BILL to amend and reenact §§ 38.2-100, 38.2-316, 38.2-1401, 38.2-1700, 38.2-1800, and 58.1-2501 of the Code of Virginia and to amend the Code of Virginia by adding in Title 38.2 a chapter numbered 61, consisting of sections numbered 38.2-6100 through 38.2-6113, relating to dental plan organizations.

Be it enacted by the General Assembly of Virginia:

1. That §§ 38.2-100, 38.2-316, 38.2-1401, 38.2-1700, 38.2-1800, and 58.1-2501 of the Code of Virginia are amended and reenacted and that the Code of Virginia is amended by adding in Title 38.2 a chapter numbered 61, consisting of sections numbered 38.2-6100 through 38.2-6113, as follows:

§ 38.2-100. Definitions.

As used in this title:

"Alien company" means a company incorporated or organized under the laws of any country other than the United States.

"Commission" means the State Corporation Commission.

"Commissioner" or "Commissioner of Insurance" means the administrative or executive officer of the division or bureau of the Commission established to administer the insurance laws of this Commonwealth.

"Company" means any association, aggregate of individuals, business, corporation, individual, joint-stock company, Lloyds type of organization, organization, partnership, receiver, reciprocal or interinsurance exchange, trustee or society.

"Domestic company" means a company incorporated or organized under the laws of this Commonwealth.

"Foreign company" means a company incorporated or organized under the laws of the United States, or of any state other than this Commonwealth.

"Health services plan" means any arrangement for offering or administering health services or similar or related services by a corporation licensed under Chapter 42 (§ 38.2-4200 et seq.) of this title.

"Insurance" means the business of transferring risk by contract wherein a person, for a consideration, undertakes (i) to indemnify another person, (ii) to pay or provide a specified or ascertainable amount of money, or (iii) to provide a benefit or service upon the occurrence of a determinable risk contingency. Without limiting the foregoing, "insurance" shall include (i) each of the classifications of insurance set forth in Article 2 (§ 38.2-101 et seq.) of this chapter and (ii) the issuance of group and individual contracts, certificates, or evidences of coverage by any health services plan as provided for in Chapter 42 (§ 38.2-4200 et seq.) of this title, health maintenance organization as provided for in Chapter 43 (§ 38.2-4300 et seq.) of this title, legal services organization or legal services plan as provided for in Chapter 44 (§ 38.2-4400 et seq.) of this title, ~~and~~ dental or optometric services plan as provided for in Chapter 45 (§ 38.2-4500 et seq.) of this title, *and dental plan organization as provided for in Chapter 61 (§ 38.2-6100 et seq.) of this title*. "Insurance" shall not include any activity involving an extended service contract that is subject to regulation pursuant to Chapter 34 (§ 59.1-435 et seq.) of Title 59.1 or a warranty made by a manufacturer, seller, lessor, or builder of a product or service.

"Insurance company" means any company engaged in the business of making contracts of insurance.

"Insurance transaction," "insurance business," and "business of insurance" include solicitation, negotiations preliminary to execution, execution of an insurance contract, and the transaction of matters subsequent to execution of the contract and arising out of it.

"Insurer" means an insurance company.

"Medicare" means the "Health Insurance for the Aged Act," Title XVIII of the Social Security Amendment of 1965, as amended.

"Person" means any association, aggregate of individuals, business, company, corporation, individual, joint-stock company, Lloyds type of organization, organization, partnership, receiver, reciprocal or interinsurance exchange, trustee or society.

"Rate" or "rates" means any rate of premium, policy fee, membership fee or any other charge made by an insurer for or in connection with a contract or policy of insurance. The terms "rate" or "rates" shall not include a membership fee paid to become a member of an organization or association, one of the benefits of which is the purchasing of insurance coverage.

"Rate service organization" means any organization or person, other than a joint underwriting

association under § 38.2-1915 or any employee of an insurer including those insurers under common control or management, who assists insurers in ratemaking or filing by:

(a) Collecting, compiling, and furnishing loss or expense statistics;

(b) Recommending, making or filing rates or supplementary rate information; or

(c) Advising about rate questions, except as an attorney giving legal advice.

"State" means any commonwealth, state, territory, district or insular possession of the United States.

"Surplus to policyholders" means the excess of total admitted assets over the liabilities of an insurer, and shall be the sum of all capital and surplus accounts, including any voluntary reserves, minus any impairment of all capital and surplus accounts.

Without otherwise limiting the meaning of or defining the following terms, "insurance contracts" or "insurance policies" shall include contracts of fidelity, indemnity, guaranty and suretyship.

§ 38.2-316. Policy forms to be filed with Commission; notice of approval or disapproval; exceptions.

A. No policy of life insurance, industrial life insurance, variable life insurance, modified guaranteed life insurance, group life insurance, accident and sickness insurance, or group accident and sickness insurance; no annuity, modified guaranteed annuity, pure endowment, variable annuity, group annuity, group modified guaranteed annuity, or group variable annuity contract; no health services plan, legal services plan, dental or optometric services plan, or health maintenance organization contract; *no dental plan organization dental benefit contract;* and no fraternal benefit certificate nor any certificate or evidence of coverage issued in connection with such policy, contract, or plan issued or issued for delivery in Virginia shall be delivered or issued for delivery in this Commonwealth unless a copy of the form has been filed with the Commission. In addition to the above requirement, no policy of accident and sickness insurance shall be delivered or issued for delivery in this Commonwealth unless the rate manual showing rates, rules, and classification of risks applicable thereto has been filed with the Commission.

B. Except as provided in this section, no application form shall be used with the policy or contract and no rider or endorsement shall be attached to or printed or stamped upon the policy or contract unless the form of such application, rider or endorsement has been filed with the Commission. No individual certificate and no enrollment form shall be used in connection with any group life insurance policy, group accident and sickness insurance policy, group annuity contract, or group variable annuity contract unless the form for the certificate and enrollment form have been filed with the Commission.

C. 1. None of the policies, contracts, and certificates specified in subsection A of this section shall be delivered or issued for delivery in this Commonwealth and no applications, enrollment forms, riders, and endorsements shall be used in connection with the policies, contracts, and certificates unless the forms thereof have been approved in writing by the Commission as conforming to the requirements of this title and not inconsistent with law.

2. In addition to the above requirement, no premium rate change applicable to individual accident and sickness insurance policies, subscriber contracts of health services plans, dental or optometric services plans, or fraternal benefit contracts providing individual accident and sickness coverage as authorized in § 38.2-4116 shall be used unless the premium rate change has been approved in writing by the Commission. No premium rate change applicable to individual or group Medicare supplement policies shall be used unless the premium rate change has been approved in writing by the Commission.

D. The Commission may disapprove or withdraw approval of the form of any policy, contract or certificate specified in subsection A of this section, or of any application, enrollment form, rider or endorsement, if the form:

1. Does not comply with the laws of this Commonwealth;

2. Has any title, heading, backing or other indication of the contents of any or all of its provisions that is likely to mislead the policyholder, contract holder or certificate holder; or

3. Contains any provisions that encourage misrepresentation or are misleading, deceptive or contrary to the public policy of this Commonwealth.

E. Within ~~thirty~~*30* days after the filing of any form requiring approval, the Commission shall notify the organization filing the form of its approval or disapproval of the form which has been filed, and, in the event of disapproval, its reason therefor. The Commission, at its discretion, may extend for up to an additional ~~thirty~~*30* days the period within which it shall approve or disapprove the form. Any form received but neither approved nor disapproved by the Commission shall be deemed approved at the expiration of the ~~thirty~~*30* days if the period is not extended, or at the expiration of the extended period, if any; however, no organization shall use a form deemed approved under the provisions of this section until the organization has filed with the Commission a written notice of its intent to use the form together with a copy of the form and the original transmittal letter thereof. The notice shall be filed in the offices of the Commission at least ~~ten~~ *10* days prior to the organization's use of the form.

F. If the Commission proposes to withdraw approval previously given or deemed given to the form of any policy, contract or certificate, or of any application, rider or endorsement, it shall notify the insurer in writing at least ~~fifteen~~ *15* days prior to the proposed effective date of withdrawal giving its

reasons for withdrawal.

G. Any insurer or fraternal benefit society aggrieved by the disapproval or withdrawal of approval of any form may proceed as indicated in § 38.2-1926.

H. This section shall not apply to any special rider or endorsement on any policy, except an accident and sickness insurance policy that relates only to the manner of distribution of benefits or to the reservation of rights and benefits under such policy, and that is used at the request of the individual policyholder, contract holder or certificate holder.

I. The Commission may exempt any categories of such policies, contracts, and certificates and any applicable rate manuals from (i) the filing requirements, (ii) the approval requirements of this section, or (iii) both such requirements. The Commission may modify such requirements, subject to such limitations and conditions which the Commission finds appropriate. In promulgating an exemption, the Commission may consider the nature of the coverage, the person or persons to be insured or covered, the competence of the buyer or other parties to the contract, and other criteria the Commission considers relevant.

J. Pursuant to the authority granted by § 38.2-223, the Commission may promulgate such rules and regulations as it may deem necessary to set standards for policy and other form submissions required by this section or § 38.2-3501.

§ 38.2-1401. Definitions.

As used in this chapter:

"Admitted assets" means, for purposes of the limitations and standards imposed by Articles 1 and 2 of this chapter, the amount thereof as permitted to be reported on the statutory financial statement of the insurer most recently required to be filed with the Commission pursuant to §§ 38.2-1300 and 38.2-1301 or other similar provisions within this title, but excluding the assets allocated to separate accounts established pursuant to Article 3 (§ 38.2-1443 et seq.) of this chapter.

"Business entity" means a corporation, association, partnership, joint venture, trust, church, or religious body.

"Category 1 investment" means any investment complying with Article 1 (§ 38.2-1400 et seq.) and either Article 2 (§ 38.2-1412 et seq.) or 3 (§ 38.2-1443 et seq.), or both Articles 2 and 3, of this chapter.

"Category 2 investment" means any investment complying with Article 1, but with neither Article 2 nor Article 3, of this chapter.

"Claimants" means any owners, beneficiaries, assignees, certificate holders, or third-party beneficiaries of any insurance benefit or right arising out of and within the coverage of an insurance policy, annuity contract, benefit contract, or subscription contract.

"Date of investment" means the date on which funds are disbursed for an investment.

"Domestic governmental entity" means the United States, any state, or any municipality or district in any such state, or any political subdivision, civil division, agency or instrumentality of one or more of the foregoing.

"Fair market value" means the price that property will bring when (i) offered for sale by one who desires, but who is not obligated, to sell it; (ii) bought by one who is under no necessity of having it; and (iii) sufficient time has elapsed to allow interested buyers the opportunity to become informed of the offer for sale.

"Fixed charges" means actual interest incurred in each year on funded and unfunded debt, excluding interest on bank deposit accounts, and annual apportionment of debt discount or premium. Where interest is partially or entirely contingent upon earnings, "fixed charges" includes contingent interest payments.

"High grade obligations" means obligations which (i) are rated one or two by the Securities Valuation Office of the National Association of Insurance Commissioners or (ii) if not rated by the Securities Valuation Office, are rated in an equivalent grade by a national rating agency recognized by the Commission.

"Insurer" means a company licensed pursuant to Chapter 10 (§ 38.2-1000 et seq.), 11 (§ 38.2-1100 et seq.), 12 (§ 38.2-1200 et seq.), 25 (§ 38.2-2500 et seq.), 26 (§ 38.2-2600 et seq.), 38 (§ 38.2-3800 et seq.), 39 (§ 38.2-3900 et seq.), 40 (§ 38.2-4000 et seq.), 41 (§ 38.2-4100 et seq.), 42 (§ 38.2-4200 et seq.), 43 (§ 38.2-4300 et seq.), 45 (§ 38.2-4500 et seq.), 46 (§ 38.2-4600 et seq.) ~~or~~, 51 (§ 38.2-5100 et seq.), *or 61 (§ 38.2-6100 et seq.)* of this title.

"Life insurer" means any insurer authorized to transact life insurance or to grant annuities as defined in §§ 38.2-102 through 38.2-107 or authorized pursuant to the provisions of Chapter 38, 39, 40 or 41, or any other chapter of this title, to provide any one of the following contractual benefits in any form: death benefits, endowment benefits, annuity benefits or monument or tombstone benefits.

"Lower grade obligations" means obligations which (i) are rated four, five, or six by the Securities Valuation Office of the National Association of Insurance Commissioners or (ii) if not rated by the Securities Valuation Office, are rated in an equivalent grade by a national rating agency recognized by the Commission.

"Medium grade obligations" means obligations which (i) are rated three by the Securities Valuation Office of the National Association of Insurance Commissioners or (ii) if not rated by the Securities Valuation office, are rated in an equivalent grade by a national rating agency recognized by the Commission.

"Minimum capital and surplus" means the minimum surplus to policyholders, or minimum net worth, a particular insurer must have to obtain and maintain its license to transact business in this Commonwealth pursuant to the applicable provisions of this title. In no case shall an insurer's minimum capital and surplus be less than zero.

"Net earnings available for fixed charges" means income minus operating expenses, maintenance expenses, taxes other than income taxes, depreciation, and depletion. Extraordinary nonrecurring income and expense items are excluded from the calculation of "net earnings available for fixed charges."

"Obligation" means a bond, debenture, note or other evidence of indebtedness.

"Prohibited investment" means any investment prohibited by § 38.2-1407.

"Reserve liabilities" means those liabilities which are required to be established by an insurer for all of its outstanding insurance policies, annuity contracts, benefit contracts and subscription contracts, in accordance with this title, as amended or as hereafter amended.

"Wrap-around mortgage" means a loan made by an insurer to a borrower, secured by a mortgage or deed of trust on real property encumbered by a first mortgage or first deed of trust, where the total amount of the obligation of the borrower to the insurer under the loan is not less than the sum of (i) the principal amount initially disbursed by the insurer on account of the loan and (ii) the unpaid principal balance of the obligation secured by the preexisting mortgage or deed of trust.

§ 38.2-1700. Purpose and applicability of chapter.

A. The purpose of this chapter is to protect, subject to certain limitations, policyowners, insureds, beneficiaries, annuitants, payees, and assignees of life insurance policies, accident and sickness insurance policies, annuity contracts, and supplemental contracts against failure to fulfill contractual obligations due to the impairment or insolvency of the insurers issuing those policies or contracts. To provide this protection, (i) an association of insurers is created to enable the guaranty of payment of benefits and of continuation of coverages, (ii) members of the Association are subject to assessments to provide funds to carry out the purpose of this chapter, and (iii) the Association is authorized to assist the Commission, in the prescribed manner, in the detection and prevention of insurer impairments or insolvencies.

B. This chapter shall apply to direct life insurance policies, accident and sickness insurance policies, annuity contracts, and contracts supplemental to life, accident and sickness insurance policies and annuity contracts issued by insurers licensed to transact insurance in this Commonwealth at any time. *This chapter shall apply also to dental benefit contracts entered into with a dental plan organization as provided in Chapter 61 (§ 38.2-6100 et seq.) of this title.*

C. This chapter shall not apply to:

1. That portion or part of a variable life insurance or variable annuity contract not guaranteed by an insurer;

2. That portion or part of any policy or contract under which the risk is borne by the policyholder;

3. Any policy or contract, or part of a policy or contract assumed by the impaired or insolvent insurer under a contract of reinsurance, other than reinsurance for which assumption certificates have been issued;

4. Any policy or contract issued by cooperative nonprofit life benefit companies, mutual assessment life, accident and sickness insurance companies, burial societies, fraternal benefit societies, dental and optometric services plans and health services plans not subject to § 38.2-4213; or

5. Any contract or certificate which is not issued to and owned by an individual, except to the extent of (i) any annuity benefits guaranteed to an individual by an insurer under such contract or certificate, (ii) any annuity benefits payable for the benefit of an individual by an insurer under an annuity contract issued to fund a structured settlement agreement on account of personal injury or sickness, or (iii) any life insurance benefits and accident and sickness insurance benefits guaranteed payable to any person by an insurer.

D. This chapter shall provide coverage for the policies and contracts specified in subsection B:

1. To persons who, regardless of where they reside (except for nonresident certificate holders under group policies or contracts), are the beneficiaries, assignees or payees of the persons covered under subdivision 2;

2. To persons who are owners of or certificate holders under such policies or contracts (other than structured settlement annuities), and who

a. are residents, or

b. are not residents, but only under all of the following conditions: (i) the insurers which issued such policies or contracts are domiciled in this state; (ii) such insurers at the time of issuance of such policies or contracts did not hold a license or certificate of authority in the states in which such persons reside; and (iii) such persons are not eligible for coverage by an association of another state where such

association is similar to the association created by this chapter; and

3. For structured settlement annuities described in clause (ii) of subdivision C 5, subdivisions 1 and 2 of this subsection shall not apply, and this chapter shall provide coverage to a person who is a payee (or beneficiary of a payee if the payee is deceased) under such a structured settlement annuity, if the payee (i) is a resident, regardless of where the contract owner resides, or (ii) is not a resident, but only under both of the following conditions: (a) (1) the contract owner of the structured settlement annuity is a resident or (2) the contract owner of the structured settlement annuity is not a resident, but the insurer that issued the structured settlement annuity is domiciled in this Commonwealth, and the state in which the contract owner resides has an association similar to the association created by this chapter, and (b) neither the payee (or beneficiary) nor the contract owner is eligible for coverage by the association of the state in which the payee or contract owner resides. In determining the application of the provisions of this subdivision in situations where a person could be covered by the association of more than one state, whether as an owner, payee, beneficiary or assignee, this subdivision shall be construed in conjunction with other state laws to result in coverage by only one association.

E. Any member insurer which has been declared insolvent and is placed under a final order of liquidation, rehabilitation, or conservation by a court of competent jurisdiction prior to July 1, 1991, shall be subject to the provisions of Chapter 17 as this chapter existed prior to July 1, 1991.

§ 38.2-1800. Definitions.

As used in this chapter:

"Agent," "insurance agent," "producer," or "insurance producer," when used without qualification, means an individual or business entity that sells, solicits, or negotiates contracts of insurance or annuity in this Commonwealth.

"Appointed agent," "appointed insurance agent," "appointed producer," or "appointed insurance producer," when used without qualification, means an individual or business entity licensed in this Commonwealth to sell, solicit, or negotiate contracts of insurance or annuity of the classes authorized within the scope of such license and who is appointed by a company licensed in this Commonwealth to sell, solicit, or negotiate on its behalf contracts of insurance of the classes authorized within the scope of such license and, if authorized by the company, may collect premiums on those contracts.

"Automobile club authority" means the authority in this Commonwealth to sell, solicit, or negotiate automobile club contracts on behalf of automobile clubs licensed under Chapter 3.1 (§ 13.1-400.1 et seq.) of Title 13.1.

"Business entity" means a partnership, limited partnership, limited liability company, corporation, or other legal entity other than a sole proprietorship.

"Dental plan organization authority" means the authority in the Commonwealth to sell, solicit, or negotiate dental benefit contracts on behalf of dental plan organizations licensed under Chapter 61 (§ 38.2-6100 et seq.) of this title.

"Dental services authority" means the authority in this Commonwealth to sell, solicit, or negotiate dental services plan contracts on behalf of dental services plans licensed under Chapter 45 (§ 38.2-4500 et seq.) of this title.

"Filed" means received by the Commission.

"Health agent" means an agent licensed in this Commonwealth to sell, solicit, or negotiate insurance as defined in §§ 38.2-108 and 38.2-109, and including contracts issued by insurers, health services plans, health maintenance organizations, dental services plans, ~~and~~ optometric services plans, *and dental plan organizations* licensed in this Commonwealth.

"Home protection insurance authority" means the authority in this Commonwealth to sell, solicit, or negotiate home protection insurance as defined in § 38.2-129 on behalf of insurers licensed in this Commonwealth.

"Home state" means the District of Columbia and any state or territory of the United States, except Virginia, or any province of Canada, in which an insurance producer maintains such person's principal place of residence or principal place of business and is licensed by that jurisdiction to act as a resident insurance producer.

"Legal services insurance authority" means the authority in this Commonwealth to sell, solicit, or negotiate legal services insurance as defined in § 38.2-127 on behalf of insurers licensed in this Commonwealth.

"Legal services plan authority" means the authority in this Commonwealth to sell, solicit, or negotiate legal services plan contracts on behalf of legal services plans licensed under Chapter 44 (§ 38.2-4400 et seq.) of this title.

"License" means a document issued by the Commission authorizing an individual or business entity to act as an insurance producer for the lines of authority specified in the document. Except as provided in § 38.2-1833, the license itself does not create any authority, actual, apparent or inherent, in the licensee to represent, commit, or bind an insurer.

"Licensed agent," "licensed insurance agent," "licensed producer," or "licensed insurance producer," when used without qualification, means an individual or business entity licensed in this Commonwealth to sell, solicit, or negotiate contracts of insurance or annuity of the classes authorized within the scope of such license.

"Life and annuities insurance agent" means an agent licensed in this Commonwealth to sell, solicit, or negotiate life insurance and annuity contracts as defined in §§ 38.2-102, 38.2-103, 38.2-104, 38.2-105.1, 38.2-106, and 38.2-107.1, respectively, on behalf of insurers licensed in this Commonwealth.

"Limited burial insurance authority" means the authority in this Commonwealth to sell, solicit, or negotiate burial insurance society membership where the certificates of membership will not exceed $7,500 on any individual, on behalf of insurers licensed under Chapter 40 (§ 38.2-4000 et seq.) of this title; or to represent an association referred to in § 38.2-3318.1, limited to soliciting members of that association for burial association group life insurance certificates in amounts of $7,500 or less.

"Limited lines credit insurance agent" means an agent licensed in this Commonwealth whose authority is restricted to selling, soliciting, or negotiating, on behalf of insurers licensed in this Commonwealth, one or more of the following coverages to individuals through a master, corporate, group or individual policy: (i) credit life insurance and credit accident and sickness insurance, but only to the extent authorized in Chapter 37.1 (§ 38.2-3717 et seq.) of this title; (ii) credit involuntary unemployment insurance as defined in § 38.2-122.1; (iii) credit property insurance, as defined in § 38.2-122.2; (iv) mortgage accident and sickness insurance; (v) mortgage redemption insurance; (vi) mortgage guaranty insurance; and (vii) any other form of insurance offered in connection with an extension of credit that is limited to partially or wholly extinguishing that credit obligation and that the Commission specifically determines may be sold, solicited, or negotiated by those holding a limited lines credit insurance agent license. Each insurer that sells, solicits or negotiates any of the coverages set forth in this definition shall provide to each individual whose duties will include selling, soliciting or negotiating such coverages a program of instruction that may, at the discretion of the Commission, be submitted for approval by the Commission or reviewed by the Commission subsequent to its implementation.

"Limited lines life and health agent" means an individual or business entity authorized by the Commission whose license authority to sell, solicit, or negotiate is limited to the following, or any other type of authority that the Commission may deem it necessary to recognize for the purposes of complying with § 38.2-1836: dental services authority; legal services plan authority; limited burial insurance authority; mutual assessment life and health insurance authority; optometric services authority; ~~and~~ travel accident insurance authority*; and dental plan organization authority*. Limited lines life and health insurance shall not include life insurance, health insurance, property insurance, casualty insurance, and title insurance.

"Limited lines property and casualty agent" means an individual or business entity authorized by the Commission whose license authority to sell, solicit, or negotiate is limited to the following, or any other type of authority that the Commission may deem it necessary to recognize for the purposes of complying with § 38.2-1836: automobile club authority; home protection insurance authority; legal services insurance authority; mutual assessment property and casualty insurance authority; ocean marine insurance authority; pet accident, sickness and hospitalization insurance authority; and travel baggage insurance authority. Limited lines property and casualty insurance shall not include life insurance, health insurance, property insurance, casualty insurance, and title insurance.

"Mortgage accident and sickness insurance authority" means the authority in this Commonwealth to sell, solicit, or negotiate mortgage accident and sickness insurance on behalf of insurers licensed in this Commonwealth.

"Mortgage guaranty insurance authority" means the authority in this Commonwealth to sell, solicit, or negotiate mortgage guaranty insurance on behalf of insurers licensed in this Commonwealth.

"Mortgage redemption insurance authority" means the authority in this Commonwealth to sell, solicit, or negotiate mortgage redemption insurance on behalf of insurers licensed in this Commonwealth. As used in this chapter, "mortgage redemption insurance" means a nonrenewable, nonconvertible, decreasing term life insurance policy written in connection with a mortgage transaction for a period of time coinciding with the term of the mortgage. The initial sum shall not exceed the amount of the indebtedness outstanding at the time the insurance becomes effective, rounded up to the next $1,000.

"Motor vehicle rental contract enroller" means an unlicensed hourly or salaried employee of a motor vehicle rental company that is in the business of providing primarily private motor vehicles to the public under a rental agreement for a period of less than six months, and receives no direct or indirect commission from the insurer, the renter or the vehicle rental company.

"Motor vehicle rental contract insurance agent" means a person who (i) is a selling agent of a motor vehicle rental company that is in the business of providing primarily private passenger motor vehicles to the public under a rental agreement for a period of less than six months and (ii) whose license in this Commonwealth is restricted to selling, soliciting, or negotiating only the following insurance coverages,

and solely in connection with and incidental to the rental contract:

1. Personal accident insurance which provides benefits in the event of accidental death or injury occurring during the rental period;

2. Liability coverage sold to the renter in excess of the rental company's obligations under §§ 38.2-2204, 38.2-2205, or Title 46.2, as applicable;

3. Personal effects insurance which provides coverages for the loss of or damage to the personal effects of the renter and other vehicle occupants while such personal effects are in or upon the rental vehicle during the rental period;

4. Roadside assistance and emergency sickness protection programs; and

5. Other travel-related or vehicle-related insurance coverage that a motor vehicle rental company offers in connection with and incidental to the rental of vehicles.

The term "motor vehicle rental contract insurance agent" does not include motor vehicle rental contract enrollers.

"Mutual assessment life and health insurance authority" means the authority in this Commonwealth to sell, solicit, or negotiate mutual assessment life and accident and sickness insurance on behalf of insurers licensed under Chapter 39 (§ 38.2-3900 et seq.) of this title, but only to the extent permitted under § 38.2-3919.

"Mutual assessment property and casualty insurance authority" means the authority in this Commonwealth to sell, solicit, or negotiate mutual assessment property and casualty insurance on behalf of insurers licensed under Chapter 25 (§ 38.2-2500 et seq.) of this title, but only to the extent permitted under § 38.2-2525.

"NAIC" means the National Association of Insurance Commissioners.

"Negotiate" means the act of conferring directly with or offering advice directly to a purchaser or prospective purchaser of a particular contract of insurance concerning any of the substantive benefits, terms or conditions of the contract, provided that the person engaged in that act either sells insurance or obtains insurance from insurers for purchasers.

"Ocean marine insurance authority" means the authority in this Commonwealth to sell, solicit, or negotiate those classes of insurance classified in § 38.2-126, except those classes specifically classified as inland marine insurance, on behalf of insurers licensed in this Commonwealth.

"Optometric services authority" means the authority in this Commonwealth to sell, solicit, or negotiate optometric services plan contracts on behalf of optometric services plans licensed under Chapter 45 (§ 38.2-4500 et seq.) of this title.

"Personal lines agent" means an agent licensed in this Commonwealth to sell, solicit, or negotiate insurance as defined in §§ 38.2-110 through 38.2-114, 38.2-116, 38.2-117, 38.2-118, 38.2-124, 38.2-125, 38.2-126, 38.2-129, 38.2-130, and 38.2-131 for transactions involving insurance primarily for personal, family, or household needs rather than for business or professional needs.

"Pet accident, sickness and hospitalization insurance authority" means the authority in this Commonwealth to sell, solicit, or negotiate pet accident, sickness and hospitalization insurance on behalf of insurers licensed in this Commonwealth.

"Property and casualty insurance agent" means an agent licensed in this Commonwealth to sell, solicit, or negotiate both personal and commercial lines of insurance as defined in §§ 38.2-110 through 38.2-122.2, and §§ 38.2-124 through 38.2-134 on behalf of insurers licensed in this Commonwealth.

"Resident" means (i) an individual residing in Virginia; (ii) an individual residing outside of Virginia whose principal place of business is in Virginia, who is able to demonstrate to the satisfaction of the Commission that the laws of his home state prevent him from obtaining a resident agent license in that state, and who affirmatively chooses to qualify as and be treated as a resident of Virginia for purposes of licensing and continuing education, both in Virginia and in the state in which the individual resides, if applicable; (iii) a partnership duly formed and recorded in Virginia; (iv) a corporation incorporated and existing under the laws of Virginia; (v) a limited liability company organized and existing under the laws of Virginia; or (vi) a foreign business entity that is not licensed as a resident agent in any other jurisdiction, and that demonstrates to the satisfaction of the Commission that its principal place of business is within the Commonwealth of Virginia.

"Restricted nonresident health agent" means a nonresident agent whose license authority in his home state does not include all of the authority granted under a health agent license in Virginia. The license issued to such agent shall authorize the agent to sell, solicit, or negotiate in Virginia, on behalf of insurers licensed in Virginia, only those kinds or classes of insurance for which the agent is authorized in his home state.

"Restricted nonresident life and annuities agent" means a nonresident agent whose license authority in his home state does not include all of the authority granted under a life and annuities agent license in Virginia. The license issued to such agent shall authorize the agent to sell, solicit, or negotiate in Virginia, on behalf of insurers licensed in Virginia, only those kinds or classes of insurance for which

the agent is authorized in his home state.

"Restricted nonresident personal lines agent" means a nonresident agent whose license authority in his home state does not include all of the authority granted under a personal lines agent license in Virginia. The license issued to such agent shall authorize the agent to sell, solicit, or negotiate in Virginia, on behalf of insurers licensed in Virginia, only those kinds or classes of insurance for which the agent is authorized in his home state.

"Restricted nonresident property and casualty agent" means a nonresident agent whose license authority in his home state does not include all of the authority granted under a property and casualty agent license in Virginia. The license issued to such agent shall authorize the agent to sell, solicit, or negotiate in Virginia, on behalf of insurers licensed in Virginia, only those kinds or classes of insurance for which the agent is authorized in his home state.

"Sell" means to exchange a contract of insurance by any means, for money or its equivalent, on behalf of an insurer.

"Settlement agent" means a person licensed as a title insurance agent and registered with the Virginia State Bar pursuant to Chapter 1.3 (§ 6.1-2.19 et seq.) of Title 6.1.

"Solicit" means attempting to sell insurance or asking or urging a person to apply for a particular class of insurance from one or more insurers.

"Surety bail bondsman" means a person licensed pursuant to Article 6.2 (§ 38.2-1865.6 et seq.) of this chapter who sells, solicits, or negotiates surety insurance as defined in § 38.2-121 on behalf of insurers licensed in this Commonwealth, pursuant to which the insurer becomes surety on or guarantees a bond, as defined in § 19.2-119, that has been posted to assure performance of terms and conditions specified by order of an appropriate judicial officer as a condition of bail.

"Surplus lines broker" means a person licensed pursuant to Article 5.1 (§ 38.2-1857.1 et seq.) of this chapter, and who is thereby authorized to engage in the activities set forth in Chapter 48 (§ 38.2-4800 et seq.) of this title.

"Terminate" means the cancellation of the relationship between an insurance producer and the insurer, or the termination of an insurance producer's authority to transact insurance.

"Title insurance agent" means an agent licensed in this Commonwealth to sell, solicit, or negotiate title insurance, and performing all of the services set forth in § 38.2-4601.1, on behalf of title insurance companies licensed under Chapter 46 (§ 38.2-4600 et seq.) of this title.

"Travel accident insurance authority" means the authority in this Commonwealth to sell, solicit, or negotiate travel accident insurance to individuals on behalf of insurers licensed in this Commonwealth.

"Travel baggage insurance authority" means the authority in this Commonwealth to sell, solicit, or negotiate travel baggage insurance to individuals on behalf of insurers licensed in this Commonwealth.

"Uniform Application" means the current version of the NAIC Uniform Application for resident and nonresident producer licensing.

"Uniform Business Entity Application" means the current version of the NAIC Uniform Business Entity Application for resident and nonresident business entities.

"Variable contract agent" means an agent licensed in this Commonwealth to sell, solicit, or negotiate variable life insurance and variable annuity contracts on behalf of insurers licensed in this Commonwealth.

"Viatical settlement broker" means a person licensed pursuant to Chapter 60 (§ 38.2-6000 et seq.) of this title, in accordance with Article 6.1 (§ 38.2-1865.1 et seq.) of this chapter, and who is thereby authorized to engage in the activities set forth in Chapter 60 (§ 38.2-6000 et seq.) of this title.

CHAPTER 61.

DENTAL PLAN ORGANIZATIONS.

§ 38.2-6100. Applicability of chapter.

A. Except as otherwise provided by law, no dental plan organization shall be organized, conducted, or offered in the Commonwealth other than in the manner set forth in this chapter.

B. This chapter shall not apply to a prepaid dental services plan organized under Chapter 45 (§ 38.2-4500 et seq.) of this title, a health maintenance organization or limited health care services plan licensed to provide dental services under Chapter 43 (§ 38.2-4300 et seq.) of this title, any health service plan licensed under Chapter 42 (§ 38.2-4200 et seq.) of this title, or any insurer whose activities are regulated under other provisions of this title.

C. Nothing contained in this chapter prohibits any dentist individually, in partnership with other dentists, or as part of a professional corporation of dentists from entering into agreements directly with his own patients, or with a parent, guardian, conservator, spouse, or other family member acting on such patient's behalf, involving payment for professional services to be rendered or made available in the future.

§ 38.2-6101. Definitions.

As used in this chapter:

"Contract holder" means (i) with respect to group contracts, the organization or entity to which the

dental benefit contract is issued, and (ii) with respect to individual contracts, the individual who enters into a dental benefit contract covering the individual or the individual and dependents of the individual.

"Copayment" means the amount payable for a particular service by an enrollee in accordance with the patient charge schedule or for which the enrollee is responsible as a condition for receiving benefits under a dental benefit contract. A copayment may be expressed as a specific dollar amount or as a percentage of the allowable charge for a service.

"Dental benefit contract" means a contract that provides benefits for dental services entered into between the dental plan organization and a contract holder.

"Dental plan" means a contractual arrangement for dental services provided or arranged for, that pays benefits or is administered on an individual or group basis. A dental plan includes, but is not limited to, an arrangement where fixed indemnity benefits are paid to an individual or provider for dental services.

"Dental plan organization" means a company that provides directly or arranges for a dental plan.

"Dental service" means a service included in the current Dental Terminology Manual issued by the American Dental Association.

"Dependent" means an individual who is the spouse or child of a subscriber.

"Enrollee" means an individual or a dependent of an individual who is enrolled in a dental plan.

"Evidence of coverage" means any certificate, agreement, or contract issued to a subscriber of a group that sets out the dental services to which the enrollees are entitled.

"Fixed indemnity benefits" means the payment amount or amounts stated in the reimbursement schedule of a dental plan organization that will be paid to a subscriber, or to the subscriber's dentist, for dental services.

"Plan dentist" means any dentist, licensed by the Virginia Board of Dentistry, who has contracted with the dental plan organization or with an entity acting on behalf of the dental plan organization to provide dental services to the enrollees. A dental plan organization may, but is not required to, utilize plan dentists.

"Plan dentist contract" means a contract between the dental plan organization or an entity acting on behalf of the dental plan organization and a plan dentist.

"Subscriber" means (i) with respect to group dental benefit contracts, the person who is covered by the contract, other than as a dependent, by satisfying the eligibility requirements of the group, and (ii) with respect to individual dental benefit contracts, the individual who obtains coverage of the individual only or the individual and dependents of the individual.

§ 38.2-6102. License application.

A. No person shall establish or operate a dental plan organization in the Commonwealth without first obtaining a license from the Commission. Any business entity, which is neither an individual nor a sole proprietorship, may apply to the Commission for a license to establish and operate a dental plan organization in compliance with this chapter.

B. Each application for a license shall be verified by an officer or authorized representative of the applicant, shall be in a form prescribed by the Commission, and shall set forth or be accompanied by the following:

1. A copy of the basic organizational documents of the applicant including, but not limited to, the articles of incorporation, articles of association, partnership agreement, trust agreement, or other applicable documents, and all amendments to those documents;

2. A copy of the bylaws, rules, and regulations, or any similar document regulating the conduct of the internal affairs of the applicant;

3. A list of the name, address, official position, and biographical information on forms acceptable to the Commission of each member of the governing body and any person with authority to manage or establish policy; and a full disclosure in the application of (i) any financial interest between such person or any dentist, organization, or corporation owned or controlled by such person and the dental plan organization and (ii) the extent and nature of the financial arrangements between such person and the dental plan organization;

4. A copy of any contract made or to be made between any dentist, sponsor, or organizer of the dental plan organization, or persons listed in subdivision 3 and the applicant;

5. A copy of the evidence of coverage form to be issued to subscribers and the dental benefit contract to be issued to contract holders;

6. A copy of any group contract form that is to be issued to employers, unions, trustees, or other organizations. All group contracts shall set forth the right of subscribers to convert their coverages to an individual contract issued by the dental plan organization;

7. A financial statement or statements and any reports, certificates, or other documents the Commission considers necessary to secure a full and accurate knowledge of the applicant's affairs and financial condition;

8. A complete description of the dental plan organization and its method of operation, including (i) the method of marketing the plan, (ii) a statement regarding the sources of working capital as well as any other sources of funding, and (iii) a description of any insurance, reinsurance, or alternative coverage arrangements proposed, including excess insurance or stop loss insurance;

9. A financial feasibility plan that includes, but is not limited to, (i) detailed enrollment projections, (ii) the methodology for determining premium rates to be charged during at least the first three years of operations and extending one year beyond the anticipated break-even point certified by an actuary, and (iii) a projection, along with material assumptions, of balance sheets, cash flow statements showing capital expenditures and purchase and sale of investments, and income statements on a quarterly basis for at least three years and extending one year beyond the anticipated break-even point; and

10. Any other information the Commission may require to make the determinations required pursuant to § 38.2-6103.

§ 38.2-6103. Issuance of license; capital and surplus; impairment.

A. The Commission shall issue a license to a dental plan organization after the filing of a complete application and payment of a $500 nonrefundable application fee, if the Commission is satisfied that:

1. The persons who are responsible for conducting the affairs of the dental plan organization are trustworthy and capable of providing, arranging for, or paying benefits for the services offered by its dental plan;

2. The dental plan organization is financially responsible and may reasonably be expected to meet its obligations to enrollees. In making this determination, the Commission shall consider, among other things, the following:

a. The financial statements of the dental plan organization;

b. The adequacy of working capital;

c. Any contracts with plan dentists;

d. The deposit of acceptable securities, which shall be in an amount of no less than $50,000; and

e. The applicant's minimum capital and surplus, which shall be the greater of $750,000 or 45 days of anticipated operating expenses and incurred claims expenses.

3. Nothing in the method of operation is contrary to the public interest, as shown in the information submitted pursuant to § 38.2-6102 or Chapter 58 (§ 38.2-5800 et seq.) of this title or by independent investigation.

B. A licensed dental plan organization shall have and maintain at all times the minimum capital and surplus described in subdivision A 2 e. The licensee's capital and surplus shall be subject also to the risk-based capital requirements of Chapter 55 (§ 38.2-5500 et seq.) of this title.

1. If the Commission finds that the minimum capital and surplus of a domestic dental plan organization is impaired, the Commission shall issue an order requiring the dental plan organization to eliminate the impairment within a period not exceeding 90 days. The Commission may by order served upon the dental plan organization prohibit the dental plan organization from issuing any new dental benefit contracts while the impairment exists. If at the expiration of the designated period the dental plan organization has not satisfied the Commission that the impairment has been eliminated, an order for the rehabilitation or liquidation of the dental plan organization may be entered as provided in Chapter 15 (§ 38.2-1500 et seq.) of this title.

2. If the Commission finds an impairment of the minimum capital and surplus of any foreign dental plan organization, the Commission may order the dental plan organization to eliminate the impairment. The Commission may, by order served upon the dental plan organization, prohibit the dental plan organization from issuing any new dental benefit contracts while the impairment exists. If the dental plan organization fails to comply with the Commission's order within a period of not more than 90 days, the Commission may suspend or revoke the license of the dental plan organization.

§ 38.2-6104. License renewals.

A. Each dental plan organization organized under this chapter shall obtain an annual renewal of its license from the Commission by July 1 of each year. The Commission may refuse to renew the license of any dental plan organization or may renew the license, subject to any restrictions considered appropriate by the Commission, if it finds an impairment of the minimum capital and surplus or that the dental plan organization has not satisfied all of the conditions set forth in subsection A of § 38.2-6103.

B. The Commission shall not fail or refuse to renew the license of any dental plan organization without first giving the dental plan organization 10 days' notice of its intention not to renew the license and giving it an opportunity to be heard and to introduce evidence on its behalf. The hearing may be informal and the required notice may be waived by the Commission and the dental plan organization.

§ 38.2-6105. Required dental benefit contract provisions.

A. Each dental benefit contract shall contain the following provisions:

1. An effective date of the contract;

2. A provision describing the payment of required subscription fees or premiums;

3. A grace period provision that complies with § 38.2-6107;

4. For group dental benefit contracts, the eligibility requirements and effective date of coverage for subscribers of the group and their dependents;

5. A provision describing the benefits available under the dental benefit contract;

6. A provision describing the copayments and deductibles for which the enrollee is responsible or the fixed indemnity benefits, if any;

7. A provision describing the service area, if applicable;

8. If a dental plan organization provides benefits only within a stated service area, a provision providing for emergency dental services outside the service area, with the term "emergency" including care to alleviate acute pain;

9. A provision indicating that if a plan dentist refers the enrollee to a specialist who is not a plan dentist for dental services that are covered under the dental benefit contract, the dental plan organization shall be responsible for payment of the specialist's charges to the extent the charges exceed the copayment specified in the dental benefit contract;

10. A provision that reads substantially as follows, if the contract requires use of a plan dentist:

"If during the term of this contract none of the plan dentists can render necessary care and treatment to the enrollee due to circumstances not reasonably within the control of the dental plan organization, such as complete or partial destruction of facilities, war, riot, civil insurrection, labor disputes, or the disability of a significant number of the plan dentists, then the enrollee may seek treatment from an independent licensed dentist of his own choosing. The dental plan organization will pay the enrollee for the expenses incurred for the dental services with the following limitations: The dental plan organization will pay the enrollee for services that are listed in the patient charge schedule as "No Charge," to the extent that such fees are reasonable and customary for dentists in the same geographic area; the dental plan organization will also pay the enrollee for those services listed in the contract for which there is a copayment, to the extent that the reasonable and customary fees for such services exceed the copayment for such services as set forth in the contract. The enrollee may be required to give written proof of loss.";

11. A provision setting out the terms under which coverage will terminate; and

12. A provision setting out a grievance procedure that specifies the time period in which the dental plan organization shall initially respond to an enrollee's grievance, with the time period not exceeding 20 days from the date the grievance is filed with the dental plan organization.

B. Each dental benefit contract shall also have provisions related to extension of benefits that specify:

1. If an enrollee's coverage terminates, an extension of benefits shall be provided for any treatment in progress at the time of termination, provided the treatment requires two or more visits to the dentist's office on separate days as certified by the treating dentist.

2. The extension of benefits shall be, at a minimum, for all types of dental care other than orthodontics, until the completion of the procedure.

3. For orthodontics, the extension of benefits will be at least 60 days if the orthodontist has agreed to or is receiving monthly payments when coverage terminates, or if the orthodontist has agreed to accept or is receiving payments on a quarterly basis, to the end of the quarter in progress or 60 days, whichever is longer.

4. An extension of benefits is not required if termination is due solely to the failure of the enrollee to pay the subscription fee or premium when the enrollee is otherwise eligible to continue coverage under the dental benefit contract.

§ 38.2-6106. Optional provisions.

Dental benefit contracts may contain the following provisions:

1. A provision including the dental plan organization's intention to charge a specified missed appointment fee. The fee shall be reasonable in relation to the nature of the procedure for which the missed appointment had been made. Neither the plan dentist nor the dental plan organization may charge a missed appointment fee unless this provision appears in the dental benefit contract. For purposes of this section, the term "missed appointment" means an appointment for which advance cancellation of at least 24 hours was not provided.

2. A provision including the dental plan organization's ability to increase premiums or subscription fees, with this provision indicating that these fees may not be increased unless:

a. The contract holder has been given written notice at least 60 days before the effective date of the increase; and

b. In the case of:

(1) An individual contract, present rates under the contract have not been changed for at least 12 months, or

(2) A group contract, present rates under the contract have been in effect for at least 12 months.

3. A provision including the dental plan organization's intention to impose a financial penalty on an

enrollee for voluntarily withdrawing from the dental plan during the first year of coverage, which penalty may not:

a. Be charged if the enrollee withdraws from the dental plan after being covered for at least 12 months; or

b. Exceed the usual, customary, and reasonable charge for services received reduced by the sum of the subscription fees paid by or for the enrollee and any copayments paid by or for the enrollee.

4. A provision including the dental plan organization's ability to increase the patient charge schedule, with the provision indicating that the increase may not be effective unless the:

a. Present schedule under the contract has been in effect for at least 12 months; and

b. Contract holder has been given written notice of the increase at least 60 days before the effective date of the increase.

5. A provision including the dental plan organization's rights if an enrollee refuses to follow a particular course of treatment. The dental plan organization may not terminate the membership of an enrollee for refusal to follow a recommended course of treatment for a particular condition. The provision may indicate that the dental plan organization may refuse to provide any further benefits for the particular condition if the enrollee refuses to accept a recommended course of treatment.

6. A provision including the dental plan organization's rights if an enrollee fraudulently uses his membership card or knowingly permits his membership card to be used by others. The dental plan organization may terminate an enrollee's coverage if the enrollee fraudulently uses his membership card or knowingly permits his membership card to be used by others. The dental plan organization may not terminate coverage for an entire family because a dependent fraudulently uses the membership card. In this instance, only the dependent's coverage may terminate.

7. A provision specifying that the dental plan organization may terminate an enrollee's coverage if the enrollee is unable to maintain a satisfactory dentist-patient relationship with a plan dentist, provided, however:

a. Before terminating the enrollee's coverage, the dental plan organization shall permit the enrollee to change primary dentists at least once;

b. The enrollee shall be given written notice of the termination at least 30 days before the termination of the enrollee's membership.

8. If the contract provides coverage for dependent children, the contract shall also contain the following provision:

"Notwithstanding any limiting age stated in the contract, any unmarried child covered under the contract as a dependent of an enrollee who is chiefly dependent for support upon the enrollee, and who, at the time of reaching the limiting age, is incapable of self-support because of mental or physical incapacity that commenced prior to the child's attaining the limiting age, shall continue to be covered under the contract while remaining so dependent, unmarried, and mentally or physically incapacitated, until the coverage on the enrollee upon whom the child is dependent terminates."

§ 38.2-6107. Grace period requirements.

The contract holder shall be given a 31-day grace period for the payment of any premium falling due after the first premium during which coverage remains in effect. If payment is not received within the 31 days, coverage may be cancelled after the thirty-first day and the contract holder may be held liable for the payment of the premium for the period of time coverage remained in effect during the grace period.

§ 38.2-6108. Plan dentist contracts; preferred providers; assignment of benefits.

A. Each contract with a plan dentist shall contain the following provisions:

1. A hold harmless clause that satisfies the requirements of subdivision C 9 of § 38.2-5805.

2. A provision specifying when the contract becomes effective.

3. A provision specifying the date the contract terminates.

4. A provision specifying the renewal terms.

5. Provisions incorporating the rights, remedies and obligations applicable to providers and dental plan organizations set forth in §§ 38.2-3407.1, 38.2-3407.10, 38.2-3407.15, and 38.2-5805.

B. A dental plan organization that offers or administers a plan under which preferred provider policies or contracts are issued shall comply with the requirements of § 38.2-3407 in contracting with dentists for services in connection with the preferred provider policies or contracts.

C. All dental plan organizations shall comply with the provisions of § 38.2-3407.13 relating to assignments of benefits by subscribers and enrollees.

§ 38.2-6109. Delivery of contract forms.

The dental plan organization:

1. Shall provide a written dental benefit contract to each group contract holder within 15 days of acceptance of the group's application by the dental plan organization;

2. Shall provide a written evidence of coverage to each individual covered under a group dental benefit contract within 15 days of acceptance of the group's application by the dental plan organization;

and

3. Shall provide a written dental benefit contract to each individual who applies for individual dental coverage within 15 days of acceptance of the individual's application by the dental plan organization;

§ 38.2-6110. Filing requirements for premium rates and subscription fees.

A. The filing with the Commission of any dental benefit contract or rider or endorsement by a dental plan organization shall be accompanied by the filing of premium rates or subscription fees.

B. A subsequent change in premium rates or subscription fees shall be filed with supporting data at least 30 days before the change is proposed to become effective.

§ 38.2-6111. Examinations.

A. The Commission shall examine the affairs of each dental plan organization as provided for in § 38.2-1317.

B. Instead of making its own examination, the Commission may accept the report of an examination of a foreign dental plan organization certified by the insurance supervisory official, similar regulatory agency, or the state health commissioner of another state.

C. The Commission may coordinate its examinations with the State Health Commissioner to ensure an appropriate level of regulatory oversight and to avoid any undue duplication of effort or regulation.

§ 38.2-6112. Licensing of agents.

Dental benefit contracts may be solicited only through health insurance agents and limited lines life and health agents licensed in accordance with Chapter 18 (§ 38.2-1800 et seq.) of this title. Home office salaried officers whose principal duties and responsibilities do not include the negotiation or solicitation of dental benefit contracts shall not be required to be licensed.

§ 38.2-6113. Application of other laws.

A. Except to the extent that such application would be inconsistent with any provision of this chapter, the provisions of Chapter 5 (§ 32.1-123 et seq.) of Title 32.1 and of other chapters of this title, and regulations promulgated thereunder, that are applicable to (i) an insurer licensed pursuant to § 38.2-1024, (ii) a carrier as defined in § 38.2-3407.10, (iii) a health plan as defined in § 38.2-3407.15, or (iv) a health carrier or managed care health insurance plan as defined in § 38.2-5800, shall apply to dental plan organizations and the provision of dental services on behalf of dental plan organizations, as if such provisions specifically stated that they apply to dental plan organizations and the provision of dental services on behalf of dental plan organizations, notwithstanding that such other provisions do not refer to dental plan organizations or the provision of dental services on behalf of dental plan organizations.

B. Any reference in this chapter to specific provisions of any other chapter of this title or of any other title shall not limit the applicability of subsection A.

§ 58.1-2501. Levy of license tax.

A. For the privilege of doing business in the Commonwealth, there is hereby levied on every insurance company defined in § 38.2-100 which issues policies or contracts for any kind of insurance classified and defined in §§ 38.2-102 through 38.2-134 and on every corporation which issues subscription contracts for any kind of plan classified and defined in §§ 38.2-4201 and 38.2-4501, an annual license tax as follows:

1. For any kind of insurance classified and defined in §§ 38.2-109 through 38.2-134 or ~~Chapter~~ *Chapters* 44 *(§ 38.2-4400 et seq.) and 61 (§ 38.2-6100 et seq.)* of Title 38.2, except workers' compensation insurance on which a premium tax is imposed under the provisions of § 65.2-1000, such company shall pay a tax of two and three-fourths percent of its subscriber fee income or direct gross premium income on such insurance for each taxable year through 1988. For taxable year 1989 and each taxable year thereafter, such company shall pay a tax of two and one-fourth percent of its subscriber fee income or direct gross premium income on such insurance.

2. For policies or contracts for life insurance as defined in § 38.2-102, such company shall pay a tax of two and one-fourth percent of its direct gross premium income on such insurance. However, with respect to premiums paid for additional benefits in the event of death, dismemberment or loss of sight by accident or accidental means, or to provide a special surrender value, special benefit or an annuity in the event of total and permanent disability, the rate of tax shall be two and three-fourths percent for each taxable year beginning January 1, 1987, through December 31, 1988, and two and one-fourth percent for taxable year beginning January 1, 1989, and each taxable year thereafter.

3. For policies or contracts providing industrial sick benefit insurance as defined in § 38.2-3544, such company shall pay a tax of one percent of its direct gross premium income on such insurance. No company, however, doing business on the legal reserve plan, shall be required to pay any licenses, fees or other taxes in excess of those required by this section on such part of its business as is industrial sick benefit insurance as defined in § 38.2-3544; but any such company doing business on the legal reserve plan shall pay on all industrial sick benefit policies or contracts on which the sick benefit portion has been cancelled as provided in § 38.2-3546, or which provide a greater death benefit than $250 or a

greater weekly indemnity than $10, and on all other life, accident and sickness insurance, the same license or other taxes as are required by this section.

4. For subscription contracts for any kind of plan classified and defined in § 38.2-4201 or § 38.2-4501, such corporation shall pay a tax of two and one-fourth percent of its direct gross subscriber fee income derived from subscription contracts issued to primary small groups as defined in § 38.2-3431 and three-fourths of one percent of its direct gross subscriber fee income derived from other subscription contracts for taxable year 1997. For each taxable year thereafter, such corporation shall pay a tax of three-fourths of one percent of its direct gross subscriber fee income derived from subscription contracts issued to individuals and from open enrollment contracts as defined in § 38.2-4216.1, and two and one-fourth percent of its direct gross subscriber fee income derived from other subscription contracts. The declaration of estimated tax pursuant to this subsection shall commence on or before April 15, 1988.

B. Notwithstanding any other provisions of this section, any domestic insurance company doing business solely in the Commonwealth which is purely mutual, has no capital stock and is not designed to accumulate profits for the benefit of or pay dividends to its members, and any domestic insurance company doing business solely in the Commonwealth, with a capital stock not exceeding $25,000 and which pays losses with assessments against its policyholders or members, shall pay an annual license tax of one percent of its direct gross premium income.