VIRGINIA ACTS OF ASSEMBLY — CHAPTER

An Act to amend and reenact §§ 38.2-508.1, 38.2-3406.1, 38.2-3407.12, 38.2-3412.1, 38.2-3412.1:01, 38.2-3417, 38.2-3418.8, 38.2-3430.3, 38.2-3431, 38.2-3432.1, 38.2-3432.2, 38.2-3436, 38.2-3438, 38.2-3439, 38.2-3440, 38.2-3442, 38.2-3444, 38.2-3501, 38.2-3503, 38.2-3520, 38.2-3521.1, 38.2-3522.1, 38.2-3523.4, 38.2-3540.2, 38.2-3551, 38.2-4109, 38.2-4214, 38.2-4306, and 38.2-4319 of the Code of Virginia; to amend the Code of Virginia by adding in Article 6 of Chapter 34 of Title 38.2 sections numbered 38.2-3447 through 38.2-3454; and to repeal § 38.2-3433 of the Code of Virginia, the third enactment of Chapter 788 of the Acts of Assembly of 2011, and the second enactment of Chapter 882 of the Acts of Assembly of 2011, relating to health insurance reform.

[H 1900]

Approved

Be it enacted by the General Assembly of Virginia:

1. That §§ 38.2-508.1, 38.2-3406.1, 38.2-3407.12, 38.2-3412.1, 38.2-3412.1:01, 38.2-3417, 38.2-3418.8, 38.2-3430.3, 38.2-3431, 38.2-3432.1, 38.2-3432.2, 38.2-3436, 38.2-3438, 38.2-3439, 38.2-3440, 38.2-3442, 38.2-3444, 38.2-3501, 38.2-3503, 38.2-3520, 38.2-3521.1, 38.2-3522.1, 38.2-3523.4, 38.2-3540.2, 38.2-3551, 38.2-4109, 38.2-4214, 38.2-4306, and 38.2-4319 of the Code of Virginia are amended and reenacted and that the Code of Virginia is amended by adding in Article 6 of Chapter 34 of Title 38.2 sections numbered 38.2-3447 through 38.2-3454 as follows:

§ 38.2-508.1. Unfair discrimination; members of the armed forces.

A. No person shall refuse to issue or refuse to continue a life insurance policy on the life of any member of the United States Armed Forces, the Reserves of the United States Armed Forces or the National Guard due to (i) their status as a member of any such military organization or (ii) their duty assignment while a member of any such military organization.

B. In circumstances where an individual's or family member's coverage under a group life or group health insurance policy or contract was terminated due to such individual's status as a member of the United States Armed Forces, the Reserves of the United States Armed Forces or the National Guard, no person shall refuse to reinstate such coverage, regardless of continuation, renewal, reissue or replacement of the group insurance policy, upon the occurrence of the individual's return to eligibility status under the policy or contract. Such reinstated coverage shall not contain any new preexisting condition or other exclusions or limitations except that the remainder of a preexisting condition requirement that was not satisfied prior to termination of the individual's coverage resulting from such military status may be applied once the individual returns and coverage under the group policy is reinstated.

C. The provisions of this section shall not apply in any instance in which the provisions of this section are inconsistent or in conflict with a provision of Article 6 (§ 38.2-3438 et seq.) of Chapter 34.

§ 38.2-3406.1. Application of requirements that policies offered by small employers include state-mandated health benefits.

A. As used in this section:

"Eligible individual" means an individual who is employed by a small employer and has satisfied applicable waiting period requirements.

"Health insurance coverage" means benefits consisting of coverage for costs of medical care, whether directly, through insurance or reimbursement, or otherwise, and including items and services paid for as medical care under a group policy of accident and sickness insurance, hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization contract, which coverage is subject to this title or is provided under a plan regulated under the Employee Retirement Income Security Act of 1974.

"Health insurer" means any insurance company that issues accident and sickness insurance policies providing hospital, medical and surgical, or major medical coverage on an expense-incurred basis, a corporation that provides accident and sickness subscription contracts, or any health maintenance organization that provides a health care plan that provides, arranges for, pays for, or reimburses any part of the cost of any health care services, that is licensed to engage in such business in the Commonwealth, and that is subject to the laws of the Commonwealth that regulate insurance within the meaning of § 514(b)(2) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. § 1144(b)(2)).

"Small employer" means, with respect to a calendar year and a plan year, an employer located in the Commonwealth that employed *an average of* at least ~~two~~ *one* but not more than 50 eligible individuals on business days during the preceding calendar year and who employs at least ~~two~~ *one* eligible

~~individuals~~ *individual* on the date a policy under this section becomes effective. *Effective January 1, 2016, "small employer" means, with respect to a calendar year and a plan year, an employer located in the Commonwealth that employed an average of at least one but not more than 100 employees on business days during the preceding calendar year and who employs at least one employee on the date a policy under this section becomes effective.*

"State-mandated health benefit" means coverage required under this title or other laws of the Commonwealth to be provided in a policy of accident and sickness insurance or a contract for a health-related condition that (i) includes coverage for specific health care services or benefits; (ii) places limitations or restrictions on deductibles, coinsurance, copayments, or any annual or lifetime maximum benefit amounts; or (iii) includes a specific category of licensed health care practitioners from whom an insured is entitled to receive care. "State-mandated health benefit" includes, without limitation, any coverage, or the offering of coverage, of a benefit or provider pursuant to §§ 38.2-3407.5 through 38.2-3407.6:1, 38.2-3407.9:01, 38.2-3407.9:02, 38.2-3407.11 through 38.2-3407.11:3, 38.2-3407.16, 38.2-3408, 38.2-3411 through 38.2-3414.1, 38.2-3418 through 38.2-3418.14, or § 38.2-4221. For purposes of this article, "state-mandated health benefit" does not include a benefit that is mandated by federal law.

B. Notwithstanding any statute, rule, or regulation to the contrary, and for the purposes of this section, a group accident and sickness insurance policy providing hospital, medical and surgical, or major medical coverage on an expense-incurred basis; a group accident and sickness subscription contract providing health insurance coverage for eligible individuals; and a health care plan that provides, arranges for, pays for, or reimburses any part of the cost of any health care services that is offered, sold, or issued by a health insurer to a small employer:

1. Shall not be required to include coverage, or the offer of coverage, for any state-mandated health benefit, except for:

a. Coverage for mammograms pursuant to § 38.2-3418.1;

b. Coverage for pap smears pursuant to § 38.2-3418.1:2;

c. Coverage for PSA testing pursuant to § 38.2-3418.7; and

d. Coverage for colorectal cancer screening pursuant to § 38.2-3418.7:1.

2. May include any, or none, of the state-mandated health benefits not otherwise noted in subdivision B 1 as the health insurer and the small employer shall agree.

Notwithstanding any provision of this section to the contrary, if any plan authorized by this section includes and offers health care services covered by the plan that may be legally rendered by a health care provider listed in § 38.2-3408, that plan shall allow for the reimbursement of such covered services when rendered by such provider. Unless otherwise provided in this section, this provision shall not require any benefit be provided as a covered service.

C. Any application and any enrollment form used in connection with coverage under this section shall prominently disclose that the policy, contract, or evidence of coverage is not required to provide state-mandated health benefits, shall prominently disclose any and all state-mandated health benefits that the policy, subscription contract, or evidence of coverage does not provide, and shall clearly describe all eligibility requirements.

D. A policy form, subscription contract, or evidence of coverage issued under this section to a small employer shall prominently disclose any and all state-mandated health benefits that the policy, subscription contract, or evidence of coverage does not provide. Such disclosure shall also be included in certificate forms or other evidences of coverage furnished to each participant. Health insurers proposing to issue forms providing coverage under this section shall clearly disclose the intended purposes for such policies, contracts, or evidences of coverage when submitting the forms to the Commission for approval in accordance with § 38.2-316.

E. The Commission shall adopt any regulations necessary to implement this section.

F. ~~(Expires July 1, 2014)~~ The provisions of this section shall not apply in any instance in which the provisions of this section are inconsistent or in conflict with a provision of Article 6 (§ 38.2-3438 et seq.) of Chapter 34.

§ 38.2-3407.12. Patient optional point-of-service benefit.

A. As used in this section:

"Affiliate" shall have the meaning set forth in § 38.2-1322.

"Allowable charge" means the amount from which the carrier's payment to a provider for any covered item or service is determined before taking into account any cost-sharing arrangement.

"Carrier" means:

1. Any insurer licensed under this title proposing to offer or issue accident and sickness insurance policies which are subject to Chapter 34 (§ 38.2-3400 et seq.) or 39 (§ 38.2-3900 et seq.) of this title;

2. Any nonstock corporation licensed under this title proposing to issue or deliver subscription contracts for one or more health services plans, medical or surgical services plans or hospital services

plans which are subject to Chapter 42 (§ 38.2-4200 et seq.) of this title;

3. Any health maintenance organization licensed under this title which provides or arranges for the provision of one or more health care plans which are subject to Chapter 43 (§ 38.2-4300 et seq.) of this title;

4. Any nonstock corporation licensed under this title proposing to issue or deliver subscription contracts for one or more dental or optometric services plans which are subject to Chapter 45 (§ 38.2-4500 et seq.) of this title; and

5. Any other person licensed under this title which provides or arranges for the provision of health care coverage or benefits or health care plans or provider panels which are subject to regulation as the business of insurance under this title.

"Co-insurance" means the portion of the carrier's allowable charge for the covered item or service which is not paid by the carrier and for which the enrollee is responsible.

"Co-payment" means the out-of-pocket charge other than co-insurance or a deductible for an item or service to be paid by the enrollee to the provider towards the allowable charge as a condition of the receipt of specific health care items and services.

"Cost sharing arrangement" means any co-insurance, co-payment, deductible or similar arrangement imposed by the carrier on the enrollee as a condition to or consequence of the receipt of covered items or services.

"Deductible" means the dollar amount of a covered item or service which the enrollee is obligated to pay before benefits are payable under the carrier's policy or contract with the group contract holder.

"Enrollee" or "member" means any individual who is enrolled in a group health benefit plan provided or arranged by a health maintenance organization or other carrier. If a health maintenance organization arranges or contracts for the point-of-service benefit required under this section through another carrier, any enrollee selecting the point-of-service benefit shall be treated as an enrollee of that other carrier when receiving covered items or services under the point-of-service benefit.

"Group contract holder" means any contract holder of a group health benefit plan offered or arranged by a health maintenance organization or other carrier. For purposes of this section, the group contract holder shall be the person to which the group agreement or contract for the group health benefit plan is issued.

"Group health benefit plan" shall mean any health care plan, subscription contract, evidence of coverage, certificate, health services plan, medical or hospital services plan, accident and sickness insurance policy or certificate, or other similar certificate, policy, contract or arrangement, and any endorsement or rider thereto, offered, arranged or issued by a carrier to a group contract holder to cover all or a portion of the cost of enrollees (or their eligible dependents) receiving covered health care items or services. Group health benefit plan does not mean (i) health care plans, contracts or policies issued in the individual market; (ii) coverages issued pursuant to Title XVIII of the Social Security Act, 42 U.S.C. § 1395 et seq. (Medicare), Title XIX of the Social Security Act, 42 U.S.C. § 1396 et seq. or Title XX of the Social Security Act, 42 U.S.C. § 1397 et seq. (Medicaid), 5 U.S.C. § 8901 et seq. (federal employees), 10 U.S.C. § 1071 et seq. (CHAMPUS) or Chapter 28 (§ 2.2-2800 et seq.) of Title 2.2 (state employees); (iii) accident only, credit or disability insurance, or long-term care insurance, plans providing only limited health care services under § 38.2-4300 (unless offered by endorsement or rider to a group health benefit plan), CHAMPUS supplement, Medicare supplement, or workers' compensation coverages; *or* (iv) an employee welfare benefit plan (as defined in section 3 (1) of the Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1002 (1)), which is self-insured or self-funded~~; or (v) the essential and standard health benefit plans developed pursuant to § 38.2-3431 C~~.

"Group specific administrative cost" means the direct administrative cost incurred by a carrier related to the offer of the point-of-service benefit to a particular group contract holder.

"Health care plan" shall have the meaning set forth in § 38.2-4300.

"Person" means any individual, corporation, trust, association, partnership, limited liability company, organization or other entity.

"Point-of-service benefit" means a health maintenance organization's delivery system or covered benefits, or the delivery system or covered benefits of another carrier under contract or arrangement with the health maintenance organization, which permit an enrollee (and eligible dependents) to receive covered items and services outside of the provider panel, including optometrists and clinical psychologists, of the health maintenance organization under the terms and conditions of the group contract holder's group health benefit plan with the health maintenance organization or with another carrier arranged by or under contract with the health maintenance organization and which otherwise complies with this section. Without limiting the foregoing, the benefits offered or arranged by a carrier's indemnity group accident and sickness policy under Chapter 34 (§ 38.2-3400 et seq.) of this title, health services plan under Chapter 42 (§ 38.2-4200 et seq.) of this title or preferred provider organization plan under Chapter 34 (§ 38.2-3400 et seq.) or 42 (§ 38.2-4200 et seq.) of this title which permit an enrollee

(and eligible dependents) to receive the full range of covered items and services outside of a provider panel, including optometrists and clinical psychologists, and which are otherwise in compliance with applicable law and this section shall constitute a point-of-service benefit.

"Preferred provider organization plan" means a health benefit program offered pursuant to a preferred provider policy or contract under § 38.2-3407 or covered services offered under a preferred provider subscription contract under § 38.2-4209.

"Provider" means any physician, hospital or other person, including optometrists and clinical psychologists, that is licensed or otherwise authorized in the Commonwealth to deliver or furnish health care items or services.

"Provider panel" means the participating providers or referral providers who have a contract, agreement or arrangement with a health maintenance organization or other carrier, either directly or through an intermediary, and who have agreed to provide items or services to enrollees of the health maintenance organization or other carrier.

B. To the maximum extent permitted by applicable law, every health care plan offered or proposed to be offered in this Commonwealth by a health maintenance organization licensed under this title to a group contract holder shall provide or include, or the health maintenance organization shall arrange for or contract with another carrier to provide or include, a point-of-service benefit to be provided or offered in conjunction with the health maintenance organization's health care plan as an additional benefit for the enrollee, at the enrollee's option, individually to accept or reject. In connection with its group enrollment application, every health maintenance organization shall, at no additional cost to the group contract holder, make available or arrange with a carrier to make available to the prospective group contract holder and to all prospective enrollees, in advance of initial enrollment and in advance of each reenrollment, a notice in form and substance acceptable to the Commission which accurately and completely explains to the group contract holder and prospective enrollee the point-of-service benefit and permits each enrollee to make his or her election. The form of notice provided in connection with any reenrollment may be the same as the approved form of notice used in connection with initial enrollment and may be made available to the group contract holder and prospective enrollee by the carrier in any reasonable manner.

C. To the extent permitted under applicable law, a health maintenance organization providing or arranging, or contracting with another carrier to provide, the point-of-service benefit under this section and a carrier providing the point-of-service benefit required under this section under arrangement or contract with a health maintenance organization:

1. May not impose, or permit to be imposed, a minimum enrollee participation level on the point-of-service benefit alone;

2. May not refuse to reimburse a provider of the type listed or referred to in § 38.2-3408 or § 38.2-4221 for items or services provided under the point-of-service benefit required under this section solely on the basis of the license or certification of the provider to provide such items or services if the carrier otherwise covers the items or services provided and the provision of the items or services is within the provider's lawful scope of practice or authority; and

3. Shall rate and underwrite all prospective enrollees of the group contract holder as a single group prior to any enrollee electing to accept or reject the point-of-service benefit.

D. The premium imposed by a carrier with respect to enrollees who select the point-of-service benefit may be different from that imposed by the health maintenance organization with respect to enrollees who do not select the point-of-service benefit. Unless a group contract holder determines otherwise, any enrollee who accepts the point-of-service benefit shall be responsible for the payment of any premium over the amount of the premium applicable to an enrollee who selects the coverage offered by the health maintenance organization without the point-of-service benefit and for any identifiable group specific administrative cost incurred directly by the carrier or any administrative cost incurred by the group contract holder in offering the point-of-service benefit to the enrollee. If a carrier offers the point-of-service benefit to a group contract holder where no enrollees of the group contract holder elect to accept the point-of-service benefit and incurs an identifiable group specific administrative cost directly as a consequence of the offering to that group contract holder, the carrier may reflect that group specific administrative cost in the premium charged to other enrollees selecting the point-of-service benefit under this section. Unless the group contract holder otherwise directs or authorizes the carrier in writing, the carrier shall make reasonable efforts to ensure that no portion of the cost of offering or arranging the point-of-service benefit shall be reflected in the premium charged by the carrier to the group contract holder for a group health benefit plan without the point-of-service benefit. Any premium differential and any group specific administrative cost imposed by a carrier relating to the cost of offering or arranging the point-of-service benefit must be actuarially sound and supported by a sworn certification of an officer of each carrier offering or arranging the point-of-service benefit filed with the Commission certifying that the premiums are based on sound actuarial principles and otherwise comply with this

section. The certifications shall be in a form, and shall be accompanied by such supporting information in a form acceptable to the Commission.

E. Any carrier may impose different co-insurance, co-payments, deductibles and other cost-sharing arrangements for the point-of-service benefit required under this section based on whether or not the item or service is provided through the provider panel of the health maintenance organization; provided that, except to the extent otherwise prohibited by applicable law, any such cost-sharing arrangement:

1. Shall not impose on the enrollee (or his or her eligible dependents, as appropriate) any co-insurance percentage obligation which is payable by the enrollee which exceeds the greater of: (i) thirty percent of the carrier's allowable charge for the items or services provided by the provider under the point-of-service benefit or (ii) the co-insurance amount which would have been required had the covered items or services been received through the provider panel;

2. Shall not impose on an enrollee (or his or her eligible dependents, as appropriate) a co-payment or deductible which exceeds the greatest co-payment or deductible, respectively, imposed by the carrier or its affiliate under one or more other group health benefit plans providing a point-of-service benefit which are currently offered and actively marketed by the carrier or its affiliate in the Commonwealth and are subject to regulation under this title; and

3. Shall not result in annual aggregate cost-sharing payments to the enrollee (or his or her eligible dependents, as appropriate) which exceed the greatest annual aggregate cost-sharing payments which would apply had the covered items or services been received under another group health benefit plan providing a point-of-service benefit which is currently offered and actively marketed by the carrier or its affiliate in the Commonwealth and which is subject to regulation under this title.

F. Except to the extent otherwise required under applicable law, any carrier providing the point-of-service benefit required under this section may not utilize an allowable charge or basis for determining the amount to be reimbursed or paid to any provider from which covered items or services are received under the point-of-service benefit which is not at least as favorable to the provider as that used:

1. By the carrier or its affiliate in calculating the reimbursement or payment to be made to similarly situated providers under another group health benefit plan providing a point-of-service benefit which is subject to regulation under this title and which is currently offered or arranged by the carrier or its affiliate and actively marketed in the Commonwealth, if the carrier or its affiliate offers or arranges another such group health benefit plan providing a point-of-service benefit in the Commonwealth; or

2. By the health maintenance organization in calculating the reimbursement or payment to be made to similarly situated providers on its provider panel.

G. Except as expressly permitted in this section or required under applicable law, no carrier shall impose on any person receiving or providing health care items or services under the point-of-service benefit any condition or penalty designed to discourage the enrollee's selection or use of the point-of-service benefit, which is not otherwise similarly imposed either: (i) on enrollees in another group health benefit plan, if any, currently offered or arranged and actively marketed by the carrier or its affiliate in the Commonwealth or (ii) on enrollees who receive the covered items or services from the health maintenance organization's provider panel. Nothing in this section shall preclude a carrier offering or arranging a point-of-service benefit from imposing on enrollees selecting the point-of-service benefit reasonable utilization review, preadmission certification or precertification requirements or other utilization or cost control measures which are similarly imposed on enrollees participating in one or more other group health benefit plans which are subject to regulation under this title and are currently offered and actively marketed by the carrier or its affiliates in the Commonwealth or which are otherwise required under applicable law.

H. Except as expressly otherwise permitted in this section or as otherwise required under applicable law, the scope of the health care items and services which are covered under the point-of-service benefit required under this section shall at least include the same health care items and services which would be covered if provided under the health maintenance organization's health care plan, including without limitation any items or services covered under a rider or endorsement to the applicable health care plan. Carriers shall be required to disclose prominently in all group health benefit plans and in all marketing materials utilized with respect to such group health benefit plans that the scope of the benefits provided under the point-of-service option are at least as great as those provided through the HMO's health care plan for that group. Filings of point-of-service benefits submitted to the Commission shall be accompanied by a certification signed by an officer of the filing carrier certifying that the scope of the point-of-service benefits includes at a minimum the same health care items and services as are provided under the HMO's group health care plan for that group.

I. Nothing in this section shall prohibit a health maintenance organization from offering or arranging the point-of-service benefit (i) as a separate group health benefit plan or under a different name than the health maintenance organization's group health benefit plan which does not contain the point-of-service

benefit or (ii) from managing a group health benefit plan under which the point-of-service benefit is offered in a manner which separates or otherwise differentiates it from the group health benefit plan which does not contain the point-of-service benefit.

J. Notwithstanding anything in this section to the contrary, to the extent permitted under applicable law, no health maintenance organization shall be required to offer or arrange a point-of-service benefit under this section with respect to any group health benefit plan offered to a group contract holder if the health maintenance organization determines in good faith that the group contract holder will be concurrently offering another group health benefit plan or a self-insured or self-funded health benefit plan which allows the enrollees to access care from their provider of choice whether or not the provider is a member of the health maintenance organization's panel.

K. This section shall apply only to group health benefit plans issued in the Commonwealth in the commercial group market by carriers regulated by this title and shall not apply to (i) health care plans, contracts or policies issued in the individual market; (ii) coverages issued pursuant to Title XVIII of the Social Security Act, 42 U.S.C. § 1395 et seq. (Medicare), Title XIX of the Social Security Act, 42 U.S.C. § 1396 et seq. or Title XX of the Social Security Act, 42 U.S.C. § 1397 et seq. (Medicaid), 5 U.S.C. § 8901 et seq. (federal employees), 10 U.S.C. § 1071 et seq. (CHAMPUS) or Chapter 28 (§ 2.2-2800 et seq.) of Title 2.2 (state employees); (iii) accident only, credit or disability insurance, or long-term care insurance, plans providing only limited health care services under § 38.2-4300 (unless offered by endorsement or rider to a group health benefit plan), CHAMPUS supplement, Medicare supplement, or workers' compensation coverages; *or* (iv) an employee welfare benefit plan (as defined in section 3 (1) of the Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1002 (1)), which is self-insured or self-funded~~; or (v) the essential and standard health benefit plans developed pursuant to § 38.2-3431 C~~.

L. This section shall apply to group health benefit plans issued or renewed by carriers in this Commonwealth on or after July 1, 1998.

M. Nothing in this section shall operate to limit any rights or obligations arising under ~~§§~~ 38.2-3407, 38.2-3407.7, 38.2-3407.10, 38.2-3407.11, 38.2-4209, 38.2-4209.1, 38.2-4312, or ~~§~~ 38.2-4312.1.

N. If any provision of this section or its application to any person or circumstance is held invalid for any reason in a court of competent jurisdiction, the invalidity shall not affect the other provisions or any other application of this section which shall be given effect without the invalid provision or application, and for this purpose the provisions of this section are declared severable.

§ 38.2-3412.1. Coverage for mental health and substance abuse services.

A. As used in this section:

"Adult" means any person who is 19 years of age or older.

"Alcohol or drug rehabilitation facility" means a facility in which a state-approved program for the treatment of alcoholism or drug addiction is provided. The facility shall be either (i) licensed by the State Board of Health pursuant to Chapter 5 (§ 32.1-123 et seq.) of Title 32.1 or by the Department of Behavioral Health and Developmental Services pursuant to Article 2 (§ 37.2-403 et seq.) of Chapter 4 of Title 37.2 or (ii) a state agency or institution.

"Child or adolescent" means any person under the age of 19 years.

"Inpatient treatment" means mental health or substance abuse services delivered on a twenty-four-hour per day basis in a hospital, alcohol or drug rehabilitation facility, an intermediate care facility or an inpatient unit of a mental health treatment center.

"Intermediate care facility" means a licensed, residential public or private facility that is not a hospital and that is operated primarily for the purpose of providing a continuous, structured twenty-four-hour per day, state-approved program of inpatient substance abuse services.

"Medication management visit" means a visit no more than 20 minutes in length with a licensed physician or other licensed health care provider with prescriptive authority for the sole purpose of monitoring and adjusting medications prescribed for mental health or substance abuse treatment.

"Mental health services" or "mental health benefits" means treatment for mental, emotional or nervous disorders.

"Mental health treatment center" means a treatment facility organized to provide care and treatment for mental illness through multiple modalities or techniques pursuant to a written plan approved and monitored by a physician, clinical psychologist, or a psychologist licensed to practice in this Commonwealth. The facility shall be (i) licensed by the Commonwealth, (ii) funded or eligible for funding under federal or state law, or (iii) affiliated with a hospital under a contractual agreement with an established system for patient referral.

"Outpatient treatment" means mental health or substance abuse treatment services rendered to a person as an individual or part of a group while not confined as an inpatient. Such treatment shall not include services delivered through a partial hospitalization or intensive outpatient program as defined herein.

"Partial hospitalization" means a licensed or approved day or evening treatment program that includes the major diagnostic, medical, psychiatric and psychosocial rehabilitation treatment modalities designed for patients with mental, emotional, or nervous disorders, and alcohol or other drug dependence who require coordinated, intensive, comprehensive and multi-disciplinary treatment. Such a program shall provide treatment over a period of six or more continuous hours per day to individuals or groups of individuals who are not admitted as inpatients. Such term shall also include intensive outpatient programs for the treatment of alcohol or other drug dependence which provide treatment over a period of three or more continuous hours per day to individuals or groups of individuals who are not admitted as inpatients.

"Substance abuse services" or "substance use disorder benefits" means treatment for alcohol or other drug dependence.

"Treatment" means services including diagnostic evaluation, medical, psychiatric and psychological care, and psychotherapy for mental, emotional or nervous disorders or alcohol or other drug dependence rendered by a hospital, alcohol or drug rehabilitation facility, intermediate care facility, mental health treatment center, a physician, psychologist, clinical psychologist, licensed clinical social worker, licensed professional counselor, licensed substance abuse treatment practitioner, licensed marriage and family therapist or clinical nurse specialist who renders mental health services. Treatment for physiological or psychological dependence on alcohol or other drugs shall also include the services of counseling and rehabilitation as well as services rendered by a state certified alcoholism, drug, or substance abuse counselor or substance abuse counseling assistant, limited to the scope of practice set forth in § 54.1-3507.1 or 54.1-3507.2, respectively, employed by a facility or program licensed to provide such treatment.

B. Except for group health insurance coverage issued to a large employer as defined in § 38.2-3431, each individual and group accident and sickness insurance policy or individual and group subscription contract providing coverage on an expense-incurred basis for a family member of the insured or the subscriber shall provide coverage for inpatient and partial hospitalization mental health and substance abuse services as follows:

1. Treatment for an adult as an inpatient at a hospital, inpatient unit of a mental health treatment center, alcohol or drug rehabilitation facility or intermediate care facility for a minimum period of 20 days per policy or contract year.

2. Treatment for a child or adolescent as an inpatient at a hospital, inpatient unit of a mental health treatment center, alcohol or drug rehabilitation facility or intermediate care facility for a minimum period of 25 days per policy or contract year.

3. Up to 10 days of the inpatient benefit set forth in subdivisions 1 and 2 of this subsection may be converted when medically necessary at the option of the person or the parent, as defined in § 16.1-336, of a child or adolescent receiving such treatment to a partial hospitalization benefit applying a formula which shall be no less favorable than an exchange of 1.5 days of partial hospitalization coverage for each inpatient day of coverage. An insurance policy or subscription contract described herein that provides inpatient benefits in excess of 20 days per policy or contract year for adults or 25 days per policy or contract year for a child or adolescent may provide for the conversion of such excess days on the terms set forth in this subdivision.

4. The limits of the benefits set forth in this subsection shall not be more restrictive than for any other illness, except that the benefits may be limited as set out in this subsection.

5. This subsection shall not apply to short-term travel, accident only, limited or specified disease policies or contracts, nor to policies or contracts designed for issuance to persons eligible for coverage under Title XVIII of the Social Security Act, known as Medicare, or any other similar coverage under state or federal governmental plans.

C. Except for group health insurance coverage issued to a large employer as defined in § 38.2-3431, each individual and group accident and sickness insurance policy or individual and group subscription contract providing coverage on an expense-incurred basis for a family member of the insured or the subscriber shall also provide coverage for outpatient mental health and substance abuse services as follows:

1. A minimum of 20 visits for outpatient treatment of an adult, child or adolescent shall be provided in each policy or contract year.

2. The limits of the benefits set forth in this subsection shall be no more restrictive than the limits of benefits applicable to physical illness; however, the coinsurance factor applicable to any outpatient visit beyond the first five of such visits covered in any policy or contract year shall be at least 50 percent.

3. For the purpose of this section, medication management visits shall be covered in the same manner as a medication management visit for the treatment of physical illness and shall not be counted as an outpatient treatment visit in the calculation of the benefit set forth herein.

4. For the purpose of this subsection, if all covered expenses for a visit for outpatient mental health

or substance abuse treatment apply toward any deductible required by a policy or contract, such visit shall not count toward the outpatient visit benefit maximum set forth in the policy or contract.

5. This subsection shall not apply to short-term travel, accident only, or limited or specified disease policies or contracts, nor to policies or contracts designed for issuance to persons eligible for coverage under Title XVIII of the Social Security Act, known as Medicare, or any other similar coverage under state or federal governmental plans.

D. The provisions of this section shall not be applicable to "biologically based mental illnesses," as defined in § 38.2-3412.1:01, unless coverage for any such mental illness is not otherwise available pursuant to the provisions § 38.2-3412.1:01.

E. The requirements of this section shall apply to all insurance policies and subscription contracts delivered, issued for delivery, reissued, or extended, or at any time when any term of the policy or contract is changed or any premium adjustment made.

F. Group health insurance coverage issued to a large employer as defined in § 38.2-3431 shall provide mental health and substance use disorder benefits in parity with the medical and surgical benefits contained in the coverage in accordance with the Mental Health Parity and Addiction Equity Act of 2008 (P.L. 110-343).

G. The provisions of this section shall not apply in any instance in which the provisions of this section are inconsistent or in conflict with a provision of Article 6 (§ 38.2-3438 et seq.) of Chapter 34.

§ 38.2-3412.1:01. Coverage for biologically based mental illness.

A. Notwithstanding the provisions of § 38.2-3419, each insurer proposing to issue group accident and sickness insurance policies providing hospital, medical and surgical, or major medical coverage on an expense-incurred basis; each corporation providing group accident and sickness subscription contracts; and each health maintenance organization providing a health care plan for health care services shall provide coverage for biologically based mental illnesses.

B. Except for group health insurance coverage issued to a large employer as defined in § 38.2-3431, benefits for biologically based mental illnesses may be different from benefits for other illnesses, conditions or disorders if such benefits meet the medical criteria necessary to achieve the same outcomes as are achieved by the benefits for any other illness, condition or disorder that is covered by such policy or contract. Group health insurance coverage issued to a large employer shall provide mental health and substance use disorder benefits in parity with the medical and surgical benefits contained in the coverage in accordance with the Mental Health Parity and Addiction Equity Act of 2008 (P.L. 110-343).

C. Coverage for biologically based mental illnesses shall neither be different nor separate from coverage for any other illness, condition or disorder for purposes of determining deductibles, benefit year or lifetime durational limits, benefit year or lifetime dollar limits, lifetime episodes or treatment limits, copayment and coinsurance factors, and benefit year maximum for deductibles and copayment and coinsurance factors.

D. Nothing shall preclude the undertaking of usual and customary procedures to determine the appropriateness of, and medical necessity for, treatment of biologically based mental illnesses under this option, provided that all such appropriateness and medical necessity determinations are made in the same manner as those determinations made for the treatment of any other illness, condition or disorder covered by such policy or contract.

E. For purposes of this section, a "biologically based mental illness" is any mental or nervous condition caused by a biological disorder of the brain that results in a clinically significant syndrome that substantially limits the person's functioning; specifically, the following diagnoses are defined as biologically based mental illness as they apply to adults and children: schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorder, panic disorder, obsessive-compulsive disorder, attention deficit hyperactivity disorder, autism, and drug and alcoholism addiction.

F. The provisions of this section shall not apply to (i) short-term travel, accident only, limited or specified disease policies, (ii) short-term nonrenewable policies of not more than six months' duration, (iii) policies, contracts, or plans issued in the individual market or small group markets to employers with 25 or fewer employees, or (iv) policies or contracts designed for issuance to persons eligible for coverage under Title XVIII of the Social Security Act, known as Medicare, or any other similar coverage under state or federal governmental plans.

G. The requirements of this section shall apply to all insurance policies, subscription contracts, and health care plans delivered, issued for delivery, reissued or extended on or after January 1, 2000, and to all such policies, contracts or plans to which a term is changed or any premium adjustment is made on or after such date.

H. The provisions of this section shall not apply in any instance in which the provisions of this section are inconsistent or in conflict with a provision of Article 6 (§ 38.2-3438 et seq.) of Chapter 34.

§ 38.2-3417. Deductibles and coinsurance options required.

A. An insurer issuing accident and sickness insurance or a corporation issuing subscription contracts

on an expense incurred basis shall make available in offering such coverage or contract to the potential insured or contract holder one or more of the following options under which the individual insured or group certificate holder pays for:

1. The first $100 of the cost of the services covered or benefits payable by the policy or contract during a 12-month period;

2. Twenty percent of the first $1,000 of the cost of the services covered or benefits payable by the policy or contract during a 12-month period;

3. The first $100 and 20 percent of the next $1,000 of the cost of the services covered or benefits payable by the policy or contract during a 12-month period; or

4. Any other option containing a greater deductible, coinsurance, or cost-sharing provision. However, the option shall not be inconsistent with standards established with respect to deductibles, coinsurance, or cost-sharing pursuant to § 38.2-3519.

B. As used in this section, "make available" means that the insurer or corporation shall disseminate information concerning the option or options and make a policy or contract containing the option or options available to potential insureds or contract holders at the same time and in the same manner as the insurer or corporation disseminates information concerning other policies or contracts and coverage options and makes other policies or contracts and coverage options available.

C. This section shall not apply to short-term travel, accident only, limited or specified disease, or individual conversion policies or contracts, nor to policies or contracts designed for issuance to persons eligible for coverage under Title XVIII of the Social Security Act, known as Medicare, or any other similar coverage under state or federal governmental plans.

D. The provisions of this section shall not apply in any instance in which the provisions of this section are inconsistent or in conflict with a provision of Article 6 (§ 38.2-3438 et seq.) of Chapter 34.

§ 38.2-3418.8. Coverage for clinical trials for treatment studies on cancer.

A. Notwithstanding the provisions of § 38.2-3419, each insurer proposing to issue individual or group accident and sickness insurance policies providing hospital, medical and surgical, or major medical coverage on an expense-incurred basis; each corporation providing individual or group accident and sickness subscription contracts; and each health maintenance organization providing a health care plan for health care services shall provide coverage for patient costs incurred during participation in clinical trials for treatment studies on cancer, including ovarian cancer trials, under any such policy, contract or plan delivered, issued for delivery, or renewed in this Commonwealth on and after July 1, 1999.

B. The reimbursement for patient costs incurred during participation in clinical trials for treatment studies on cancer shall be determined in the same manner as reimbursement is determined for other medical and surgical procedures. Such coverage shall have durational limits, dollar limits, deductibles, copayments and coinsurance factors that are no less favorable than for physical illness generally.

C. For purposes of this section:

"Cooperative group" means a formal network of facilities that collaborate on research projects and have an established NIH-approved peer review program operating within the group. "Cooperative group" includes (i) the National Cancer Institute Clinical Cooperative Group and (ii) the National Cancer Institute Community Clinical Oncology Program.

"FDA" means the Federal Food and Drug Administration.

"Member" means a policyholder, subscriber, insured, or certificate holder or a covered dependent of a policyholder, subscriber, insured or certificate holder.

"Multiple project assurance contract" means a contract between an institution and the federal Department of Health and Human Services that defines the relationship of the institution to the federal Department of Health and Human Services and sets out the responsibilities of the institution and the procedures that will be used by the institution to protect human subjects.

"NCI" means the National Cancer Institute.

"NIH" means the National Institutes of Health.

"Patient cost" means the cost of a medically necessary health care service that is incurred as a result of the treatment being provided to the member for purposes of a clinical trial. "Patient cost" does not include (i) the cost of nonhealth care services that a patient may be required to receive as a result of the treatment being provided for purposes of a clinical trial, (ii) costs associated with managing the research associated with the clinical trial, or (iii) the cost of the investigational drug or device.

D. Coverage for patient costs incurred during clinical trials for treatment studies on cancer shall be provided if the treatment is being conducted in a Phase II, Phase III, or Phase IV clinical trial. Such treatment may, however, be provided on a case-by-case basis if the treatment is being provided in a Phase I clinical trial.

E. The treatment described in subsection D shall be provided by a clinical trial approved by:

1. The National Cancer Institute;

2. An NCI cooperative group or an NCI center;

3. The FDA in the form of an investigational new drug application;

4. The federal Department of Veterans Affairs; or

5. An institutional review board of an institution in the Commonwealth that has a multiple project assurance contract approved by the Office of Protection from Research Risks of the NCI.

F. The facility and personnel providing the treatment shall be capable of doing so by virtue of their experience, training, and expertise.

G. Coverage under this section shall apply only if:

1. There is no clearly superior, noninvestigational treatment alternative;

2. The available clinical or preclinical data provides a reasonable expectation that the treatment will be at least as effective as the noninvestigatonal alternative; and

3. The member and the physician or health care provider who provides services to the member under the insurance policy, subscription contract or health care plan conclude that the member's participation in the clinical trial would be appropriate, pursuant to procedures established by the insurer, corporation or health maintenance organization and as disclosed in the policy and evidence of coverage.

H. The provisions of this section shall not apply to short-term travel, accident-only, limited or specified disease policies or contracts designed for issuance to persons eligible for coverage under Title XVIII of the Social Security Act, known as Medicare, or any other similar coverage under state or governmental plans or to short-term nonrenewable policies of not more than six months' duration.

I. The provisions of this section shall not apply in any instance in which the provisions of this section are inconsistent or in conflict with a provision of Article 6 (§ 38.2-3438 et seq.) of Chapter 34.

§ 38.2-3430.3. Guaranteed availability of individual health insurance coverage to certain individuals with prior group coverage.

A. Guaranteed availability.

1. All eligible individuals shall be provided a choice of all individual health insurance coverage currently being offered by a health insurance issuer and the chosen coverage shall be issued.

2. The coverage provided as required in subdivision A 1 shall not impose any preexisting condition exclusion or affiliation period with respect to the coverage.

B. Health insurance issuers are prohibited from imposing any limitations or exclusions based upon named conditions that apply to eligible individuals.

C. Health insurance issuers shall include on all applications for health insurance coverage questions which will enable the health insurance issuer to determine if an applicant is applying for coverage as an eligible individual as defined in § 38.2-3430.2. This requirement shall not apply to applications used in connection with managed health care plans administering and providing care to Medicare beneficiaries in exchange for preestablished compensation from Medicare, as permitted under applicable state and federal guidelines.

D. The provisions of this section shall not apply in any instance in which the provisions of this section are inconsistent or in conflict with a provision of Article 6 (§ 38.2-3438 et seq.) of Chapter 34.

§ 38.2-3431. Application of article; definitions.

A. This article applies to group health plans and to health insurance issuers offering group health insurance coverage, and individual policies offered to employees of small employers.

Each insurer proposing to issue individual or group accident and sickness insurance policies providing hospital, medical and surgical or major medical coverage on an expense incurred basis, each corporation providing individual or group accident and sickness subscription contracts, and each health maintenance organization or multiple employer welfare arrangement providing health care plans for health care services that offers individual or group coverage to the small employer market in this Commonwealth shall be subject to the provisions of this article. Any issuer of individual coverage to employees of a small employer shall be subject to the provisions of this article if any of the following conditions are met:

1. Any portion of the premiums or benefits is paid by or on behalf of the employer;

2. The eligible employee or dependent is reimbursed, whether through wage adjustments or otherwise, by or on behalf of the employer for any portion of the premium;

3. The employer has permitted payroll deduction for the covered individual and any portion of the premium is paid by the employer, provided that the health insurance issuer providing individual coverage under such circumstances shall be registered as a health insurance issuer in the small group market under this article, and shall have offered small employer group insurance to the employer in the manner required under this article; or

4. The health benefit plan is treated by the employer or any of the covered individuals as part of a plan or program for the purpose of §§ 106, 125, or 162 of the United States Internal Revenue Code.

B. For the purposes of this article:

"Actuarial certification" means a written statement by a member of the American Academy of Actuaries or other individual acceptable to the Commission that a health insurance issuer is in

compliance with the provisions of this article based upon the person's examination, including a review of the appropriate records and of the actuarial assumptions and methods used by the health insurance issuer in establishing premium rates for applicable insurance coverage.

"Affiliation period" means a period which, under the terms of the health insurance coverage offered by a health maintenance organization, must expire before the health insurance coverage becomes effective. The health maintenance organization is not required to provide health care services or benefits during such period and no premium shall be charged to the participant or beneficiary for any coverage during the period.

1. Such period shall begin on the enrollment date.

2. An affiliation period under a plan shall run concurrently with any waiting period under the plan.

"Beneficiary" has the meaning given such term under section 3(8) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. § 1002 (8)).

"Bona fide association" means, with respect to health insurance coverage offered in this Commonwealth, an association which:

1. Has been actively in existence for at least five years;

2. Has been formed and maintained in good faith for purposes other than obtaining insurance;

3. Does not condition membership in the association on any health status-related factor relating to an individual (including an employee of an employer or a dependent of an employee);

4. Makes health insurance coverage offered through the association available to all members regardless of any health status-related factor relating to such members (or individuals eligible for coverage through a member);

5. Does not make health insurance coverage offered through the association available other than in connection with a member of the association; and

6. Meets such additional requirements as may be imposed under the laws of this Commonwealth.

"Certification" means a written certification of the period of creditable coverage of an individual under a group health plan and coverage provided by a health insurance issuer offering group health insurance coverage and the coverage if any under such COBRA continuation provision, and the waiting period if any and affiliation period if applicable imposed with respect to the individual for any coverage under such plan.

"Church plan" has the meaning given such term under section 3(33) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. § 1002 (33)).

"COBRA continuation provision" means any of the following:

1. Section 4980B of the Internal Revenue Code of 1986 (26 U.S.C. § 4980B), other than subsection (f) (1) of such section insofar as it relates to pediatric vaccines;

2. Part 6 of subtitle B of Title I of the Employee Retirement Income Security Act of 1974 (29 U.S.C. § 1161 et seq.), other than section 609 of such Act; or

3. Title XXII of P.L. 104-191.

~~"Community rate" means the average rate charged for the same or similar coverage to all small employer groups with the same area, age and gender characteristics. This rate shall be based on the health insurance issuer's combined claims experience for all groups within its small employer market.~~

"Creditable coverage" means with respect to an individual, coverage of the individual under any of the following:

1. A group health plan;

2. Health insurance coverage;

3. Part A or B of Title XVIII of the Social Security Act (42 U.S.C. § 1395c or § 1395);

4. Title XIX of the Social Security Act (42 U.S.C. § 1396 et seq.), other than coverage consisting solely of benefits under section 1928;

5. Chapter 55 of Title 10, United States Code (10 U.S.C. § 1071 et seq.);

6. A medical care program of the Indian Health Service or of a tribal organization;

7. A state health benefits risk pool;

8. A health plan offered under Chapter 89 of Title 5, United States Code (5 U.S.C. § 8901 et seq.);

9. A public health plan (as defined in federal regulations);

10. A health benefit plan under section 5 (e) of the Peace Corps Act (22 U.S.C. § 2504(e)); or

11. Individual health insurance coverage.

Such term does not include coverage consisting solely of coverage of excepted benefits.

"Dependent" means the spouse or child of an eligible employee, subject to the applicable terms of the policy, contract or plan covering the eligible employee.

"Eligible employee" means an employee who works for a small group employer on a full-time basis, has a normal work week of 30 or more hours, has satisfied applicable waiting period requirements, and is not a part-time, temporary or substitute employee. *At the employer's sole discretion, the eligibility criterion may be broadened to include part-time employees.*

"Eligible individual" means such an individual in relation to the employer as shall be determined:

1. In accordance with the terms of such plan;

2. As provided by the health insurance issuer under rules of the health insurance issuer which are uniformly applicable to employers in the group market; and

3. In accordance with all applicable law of this Commonwealth governing such issuer and such market.

"Employee" has the meaning given such term under section 3(6) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. § 1002 (6)).

"Employer" has the meaning given such term under section 3(5) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. § 1002 (5)), except that such term shall include only employers of two or more employees.

"Enrollment date" means, with respect to an eligible individual covered under a group health plan or health insurance coverage, the date of enrollment of the eligible individual in the plan or coverage or, if earlier, the first day of the waiting period for such enrollment.

~~"Essential and standard health benefit plans" means health benefit plans developed pursuant to subsection C of this section.~~

"Excepted benefits" means benefits under one or more (or any combination thereof) of the following:

1. Benefits not subject to requirements of this article:

a. Coverage only for accident, or disability income insurance, or any combination thereof;

b. Coverage issued as a supplement to liability insurance;

c. Liability insurance, including general liability insurance and automobile liability insurance;

d. Workers' compensation or similar insurance;

e. Medical expense and loss of income benefits;

f. Credit-only insurance;

g. Coverage for on-site medical clinics; and

h. Other similar insurance coverage, specified in regulations, under which benefits for medical care are secondary or incidental to other insurance benefits.

2. Benefits not subject to requirements of this article if offered separately:

a. Limited scope dental or vision benefits;

b. Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof; and

c. Such other similar, limited benefits as are specified in regulations.

3. Benefits not subject to requirements of this article if offered as independent, noncoordinated benefits:

a. Coverage only for a specified disease or illness; and

b. Hospital indemnity or other fixed indemnity insurance.

4. Benefits not subject to requirements of this article if offered as separate insurance policy:

a. Medicare supplemental health insurance (as defined under section 1882 (g) (1) of the Social Security Act (42 U.S.C. § 1395ss (g) (1));

b. Coverage supplemental to the coverage provided under Chapter 55 of Title 10, United States Code (10 U.S.C. § 1071 et seq.); and

c. Similar supplemental coverage provided to coverage under a group health plan.

"Federal governmental plan" means a governmental plan established or maintained for its employees by the government of the United States or by an agency or instrumentality of such government.

"Governmental plan" has the meaning given such term under section 3(32) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. § 1002 (32)) and any federal governmental plan.

"Group health insurance coverage" means in connection with a group health plan, health insurance coverage offered in connection with such plan.

"Group health plan" means an employee welfare benefit plan (as defined in section 3 (1) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. § 1002 (1)), to the extent that the plan provides medical care and including items and services paid for as medical care to employees or their dependents (as defined under the terms of the plan) directly or through insurance, reimbursement, or otherwise.

"Health benefit plan" means any accident and health insurance policy or certificate, health services plan contract, health maintenance organization subscriber contract, plan provided by a MEWA or plan provided by another benefit arrangement. "Health benefit plan" does not mean accident only, credit, or disability insurance; coverage of Medicare services or federal employee health plans, pursuant to contracts with the United States government; Medicare supplement or long-term care insurance; Medicaid coverage; dental only or vision only insurance; specified disease insurance; hospital confinement indemnity coverage; limited benefit health coverage; coverage issued as a supplement to liability insurance; insurance arising out of a workers' compensation or similar law; automobile medical

payment insurance; medical expense and loss of income benefits; or insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

"Health insurance coverage" means benefits consisting of medical care (provided directly, through insurance or reimbursement, or otherwise and including items and services paid for as medical care) under any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization contract offered by a health insurance issuer.

"Health insurance issuer" means an insurance company, or insurance organization (including a health maintenance organization) which is licensed to engage in the business of insurance in this Commonwealth and which is subject to the laws of this Commonwealth which regulate insurance within the meaning of section 514 (b) (2) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. § 1144 (b) (2)). Such term does not include a group health plan.

"Health maintenance organization" means:

1. A federally qualified health maintenance organization;

2. An organization recognized under the laws of this Commonwealth as a health maintenance organization; or

3. A similar organization regulated under the laws of this Commonwealth for solvency in the same manner and to the same extent as such a health maintenance organization.

"Health status-related factor" means the following in relation to the individual or a dependent eligible for coverage under a group health plan or health insurance coverage offered by a health insurance issuer:

1. Health status;

2. Medical condition (including both physical and mental illnesses);

3. Claims experience;

4. Receipt of health care;

5. Medical history;

6. Genetic information;

7. Evidence of insurability (including conditions arising out of acts of domestic violence); or

8. Disability.

"Individual health insurance coverage" means health insurance coverage offered to individuals in the individual market, but does not include coverage defined as excepted benefits. Individual health insurance coverage does not include short-term limited duration coverage.

"Individual market" means the market for health insurance coverage offered to individuals other than in connection with a group health plan.

"Large employer" means, in connection with a group health plan or health insurance coverage with respect to a calendar year and a plan year, an employer who employed an average of at least 51 employees on business days during the preceding calendar year and who employs at least ~~two employees~~ *one employee* on the first day of the plan year. *Effective January 1, 2016, "large employer" means, in connection with a group health plan or health insurance coverage with respect to a calendar year and a plan year, an employer who employed an average of at least 101 employees on business days during the preceding calendar year and who employs at least one employee on the first day of the plan year.*

"Large group market" means the health insurance market under which individuals obtain health insurance coverage (directly or through any arrangement) on behalf of themselves (and their dependents) through a group health plan maintained by a large employer ~~or through a health insurance issuer~~.

"Late enrollee" means, with respect to coverage under a group health plan or health insurance coverage provided by a health insurance issuer, a participant or beneficiary who enrolls under the plan other than during:

1. The first period in which the individual is eligible to enroll under the plan; or

2. A special enrollment period as required pursuant to subsections J through M of § 38.2-3432.3.

"Medical care" means amounts paid for:

1. The diagnosis, cure, mitigation, treatment, or prevention of disease, or amounts paid for the purpose of affecting any structure or function of the body;

2. Transportation primarily for and essential to medical care referred to in subdivision 1; and

3. Insurance covering medical care referred to in subdivisions 1 and 2.

"Network plan" means health insurance coverage of a health insurance issuer under which the financing and delivery of medical care (including items and services paid for as medical care) are provided, in whole or in part, through a defined set of providers under contract with the health insurance issuer.

"Nonfederal governmental plan" means a governmental plan that is not a federal governmental plan.

"Participant" has the meaning given such term under section 3(7) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. § 1002 (7)).

"Placed for adoption," or "placement" or "being placed" for adoption, in connection with any placement for adoption of a child with any person, means the assumption and retention by such person of a legal obligation for total or partial support of such child in anticipation of adoption of such child. The child's placement with such person terminates upon the termination of such legal obligation.

"Plan sponsor" has the meaning given such term under section 3(16) (B) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. § 1002 (16) (B)).

"Preexisting condition exclusion" means, with respect to coverage, a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the date of enrollment for such coverage, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before such date. Genetic information shall not be treated as a preexisting condition in the absence of a diagnosis of the condition related to such information.

"Premium" means all moneys paid by an employer and eligible employees as a condition of coverage from a health insurance issuer, including fees and other contributions associated with the health benefit plan.

"Rating period" means the 12-month period for which premium rates are determined by a health insurance issuer and are assumed to be in effect.

"Service area" means a broad geographic area of the Commonwealth in which a health insurance issuer sells or has sold insurance policies on or before January 1994, or upon its subsequent authorization to do business in Virginia.

"Small employer" means in connection with a group health plan or health insurance coverage with respect to a calendar year and a plan year, an employer who employed an average of at least ~~two~~ *one* but not more than 50 employees on business days during the preceding calendar year and who employs at least ~~two employees~~ *one employee* on the first day of the plan year. *Effective January 1, 2016, "small employer" means in connection with a group health plan or health insurance coverage with respect to a calendar year and a plan year, an employer who employed an average of at least one but not more than 100 employees on business days during the preceding calendar year and who employs at least one employee on the first day of the plan year.*

"Small group market" means the health insurance market under which individuals obtain health insurance coverage (directly or through any arrangement) on behalf of themselves (and their dependents) through a group health plan maintained by a small employer ~~or through a health insurance issuer~~.

"State" means each of the several states, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands.

"Waiting period" means, with respect to a group health plan or health insurance coverage provided by a health insurance issuer and an individual who is a potential participant or beneficiary in the plan, the period that must pass with respect to the individual before the individual is eligible to be covered for benefits under the terms of the plan. If an employee or dependent enrolls during a special enrollment period pursuant to subsections J through M of § 38.2-3432.3 or as a late enrollee, any period before such enrollment is not a waiting period.

C. ~~The Commission shall adopt regulations establishing the essential and standard plans for sale in the small employer market. Such regulations shall incorporate the recommendations of the Essential Health Services Panel, established pursuant to Chapter 847 of the 1992 Acts of Assembly. The Commission shall modify such regulations as necessary to incorporate any revisions to the essential and standard plans submitted by the Special Advisory Commission on Mandated Health Insurance Benefits pursuant to § 2.2-2503. Every health insurance issuer shall, as a condition of transacting business in Virginia with small employers, offer to small employers the essential and standard plans, subject to the provisions of § 38.2-3432.2. However, any regulation adopted by the Commission shall contain a provision requiring all health insurance issuers to offer an option permitting a small employer electing to be covered under either an essential or standard health benefit plan to choose coverage that does not provide dental benefits. The regulation shall also require a small employer electing such option, as a condition of continuing eligibility for coverage pursuant to this article, to purchase separate dental coverage for all eligible employees and eligible dependents from a dental services plan authorized pursuant to Chapter 45 of this title. All health insurance issuers shall issue the plans to every small employer that elects to be covered under either one of the plans and agrees to make the required premium payments, and shall satisfy the following provisions:~~

~~1. Such plan may include cost containment and cost sharing features such as, but not limited to, utilization review of health care services including review of medical necessity of hospital and physician services; case management; selective contracting with hospitals, physicians and other health care providers, subject to the limitations set forth in §§ 38.2-3407 and 38.2-4209 and Chapter 43 (§ 38.2-4300 et seq.) of this title; reasonable benefit differentials applicable to providers that participate or do not participate in arrangements using restricted network provisions; co-payment, co-insurance, deductible or other cost sharing arrangement as those terms are defined in § 38.2-3407.12; or other~~

~~managed care provisions. The essential and standard plans for health maintenance organizations shall contain benefits and cost-sharing levels which are consistent with the basic method of operation and benefit plans of federally qualified health maintenance organizations, if a health maintenance organization is federally qualified, and of nonfederally qualified health maintenance organizations, if a health maintenance organization is not federally qualified. The essential and standard plans of coverage for health maintenance organizations shall be actuarial equivalents of these plans for health insurance issuers.~~

~~2. No law requiring the coverage or offering of coverage of a benefit or provider pursuant to § 38.2-3408 or § 38.2-4221 shall apply to the essential or standard health care plan or riders thereof.~~

~~3. Every health insurance issuer offering group health insurance coverage shall, as a condition of transacting business in Virginia with small employers, offer and make available to small employers an essential and a standard health benefit plan, subject to the provisions of § 38.2-3432.2.~~

~~4. All essential and standard benefit plans issued to small employers shall use a policy form approved by the Commission providing coverage defined by the essential and standard benefit plans. Coverages providing benefits greater than and in addition to the essential and standard plans may be provided by rider, separate policy or plan provided that no rider, separate policy or plan shall reduce benefit or premium. A health insurance issuer shall submit all policy forms, including applications, enrollment forms, policies, subscription contracts, certificates, evidences of coverage, riders, amendments, endorsements and disclosure plans to the Commission for approval in the same manner as required by § 38.2-316. Each rider, separate policy or plan providing benefits greater than the essential and standard benefit plans may require a specific premium for the benefits provided in such rider, separate policy or plan. The premium for such riders shall be determined in the same manner as the premiums are determined for the essential and standard plans. The Commission at any time may, after providing notice and an opportunity for a hearing to a health insurance issuer, disapprove the continued use by the health insurance issuer of an essential or standard health benefit plan on the grounds that such plan does not meet the requirements of this article.~~

~~5. No health insurance issuer offering group health insurance coverage is required to offer coverage or accept applications pursuant to subdivisions 3 and 4 of this subsection:~~

~~a. From a small employer already covered under a health benefit plan except for coverage that is to commence on the group's anniversary date, but this subsection shall not be construed to prohibit a group from seeking coverage or a health insurance issuer offering group health insurance coverage from issuing coverage to a group prior to its anniversary date; or~~

~~b. If the Commission determines that acceptance of an application or applications would result in the health insurance issuer being declared an impaired insurer.~~

~~A health insurance issuer offering group health insurance coverage that does not offer coverage pursuant to subdivision 5 b may not offer coverage to small employers until the Commission determines that the health insurance issuer is no longer impaired.~~

~~6. Every health insurance issuer offering group health insurance coverage shall uniformly apply the provisions of subdivision C 5 of this section and shall fairly market the essential and standard health benefit plans to all small employers in their service area of the Commonwealth. A health insurance issuer offering group health insurance coverage that fails to fairly market as required by this subdivision may not offer coverage in the Commonwealth to new small employers until the later of 180 days after the unfair marketing has been identified and proven to the Commission or the date on which the health insurance issuer submits and the Commission approves a plan to fairly market to the health insurance issuer's service area.~~

~~7. No health maintenance organization is required to offer coverage or accept applications pursuant to subdivisions 3 and 4 of this subsection in the case of any of the following:~~

~~a. To small employers, where the policy would not be delivered or issued for delivery in the health maintenance organization's approved service areas;~~

~~b. To an employee, where the employee does not reside or work within the health maintenance organization's approved service areas;~~

~~c. To small employers if the health maintenance organization is a federally qualified health maintenance organization and it demonstrates to the satisfaction of the Commission that the federally qualified health maintenance organization is prevented from doing so by federal requirement; however, any such exemption under this subdivision would be limited to the essential plan; or~~

~~d. Within an area where the health maintenance organization demonstrates to the satisfaction of the Commission, that it will not have the capacity within that area and its network of providers to deliver services adequately to the enrollees of those groups because of its obligations to existing group contract holders and enrollees. A health maintenance organization that does not offer coverage pursuant to this subdivision may not offer coverage in the applicable area to new employer groups with more than 50 eligible employees until the later of 180 days after closure to new applications or the date on which the~~

~~health maintenance organization notifies the Commission that it has regained capacity to deliver services to small employers. In the case of a health maintenance organization doing business in the small employer market in one service area of this Commonwealth, the rules set forth in this subdivision shall apply to the health maintenance organization's operations in the service area, unless the provisions of subdivision 6 of this subsection apply.~~

~~8. In order to ensure the broadest availability of health benefit plans to small employers, the Commission shall set market conduct and other requirements for health insurance issuers, agents and third-party administrators, including requirements relating to the following:~~

~~a. Registration by each health insurance issuer offering group health insurance coverage with the Commission of its intention to offer health insurance coverage in the small group market under this article;~~

~~b. Publication by the Commission of a list of all health insurance issuers who offer coverage in the small group market, including a potential requirement applicable to agents, third-party administrators, and health insurance issuers that no health benefit plan may be sold to a small employer by a health insurance issuer not so identified as a health insurance issuer in the small group market;~~

~~c. The availability of a broadly publicized toll-free telephone number for the Commission's Bureau of Insurance for access by small employers to information concerning this article;~~

~~d. To the extent deemed to be necessary to ensure the fair distribution of small employers among carriers, periodic reports by health insurance issuers about plans issued to small employers; provided that reporting requirements shall be limited to information concerning case characteristics and numbers of health benefit plans in various categories marketed or issued to small employers. Health insurance issuers shall maintain data relating to the essential and standard benefit plans separate from data relating to additional benefits made available by rider for the purpose of complying with the reporting requirements of this section; and~~

~~e. Methods concerning periodic demonstration by health insurance issuers offering group health insurance coverage that they are marketing and issuing health benefit plans to small employers in fulfillment of the purposes of this article.~~

~~9. All essential and standard health benefits plans contracts delivered, issued for delivery, reissued, renewed, or extended in this Commonwealth on or after July 1, 1997, shall include coverage for 365 days of inpatient hospitalization for each covered individual during a 12-month period. If coverage under the essential or standard health benefits plan terminates while a covered person is hospitalized, the inpatient hospital benefits shall continue to be provided until the earliest of (i) the day the maximum amount of benefit has been provided or (ii) the day the covered person is no longer hospitalized as an inpatient~~ *The provisions of this section shall not apply in any instance in which the provisions of this section are inconsistent or in conflict with a provision of Article 6 (§ 38.2-3438 et seq.) of Chapter 34.*

§ 38.2-3432.1. Renewability.

A. Every health insurance issuer that offers health insurance coverage in the group market in this Commonwealth shall renew or continue in force such coverage with respect to all insureds at the option of the employer except:

1. For nonpayment of the required premiums by the policyholder, or contract holder, or where the health insurance issuer has not received timely premium payments;

2. When the health insurance issuer is ceasing to offer coverage in the small group market in accordance with subdivisions 9 and 10;

3. For fraud or misrepresentation by the employer, with respect to their coverage;

4. With regard to coverage provided to an eligible employee, for fraud or misrepresentation by the employee with regard to his or her coverage;

5. For failure to comply with contribution and participation requirements defined by the health benefit plan;

6. For failure to comply with health benefit plan provisions that have been approved by the Commission;

7. When a health insurance issuer offers health insurance coverage in the group market through a network plan, and there is no longer an enrollee in connection with such plan who lives, resides, or works in the service area of the health insurance issuer (or in the area for which the health insurance issuer is authorized to do business) and, in the case of the group market, the health insurance issuer would deny enrollment with respect to such plan under the provisions of subdivision 9 or 10;

8. When health insurance coverage is made available in the group market only through one or more bona fide associations, the membership of an employer in the association (on the basis of which the coverage is provided) ceases but only if such coverage is terminated under this subdivision uniformly without regard to any health status related factor relating to any covered individual;

9. When a health insurance issuer decides to discontinue offering a particular type of group health insurance coverage in the group market in this Commonwealth, coverage of such type may be

discontinued by the health insurance issuer in accordance with the laws of this Commonwealth in such market only if (i) the health insurance issuer provides notice to each plan sponsor provided coverage of this type in such market (and participants and beneficiaries covered under such coverage) of such discontinuation at least ninety days prior to the date of the discontinuation of such coverage; (ii) the health insurance issuer offers to each plan sponsor provided coverage of this type in such market, the option to purchase any other health insurance coverage currently being offered by the health insurance issuer to a group health plan in such market; and (iii) in exercising the option to discontinue coverage of this type and in offering the option of coverage under this subdivision, the health insurance issuer acts uniformly without regard to the claims experience of those sponsors or any health status-related factor relating to any participants or beneficiaries covered or new participants or beneficiaries who may become eligible for such coverage;

10. In any case in which a health insurance issuer elects to discontinue offering all health insurance coverage in the group market in this Commonwealth, health insurance coverage may be discontinued by the health insurance issuer only in accordance with the laws of this Commonwealth and if: (i) the health insurance issuer provides notice to the Commission and to each plan sponsor (and participants and beneficiaries covered under such coverage) of such discontinuation at least 180 days prior to the date of the discontinuation of such coverage; and (ii) all health insurance issued or delivered for issuance in this Commonwealth in such market (or markets) are discontinued and coverage under such health insurance coverage in such market (or markets) is not renewed;

11. In the case of a discontinuation under subdivision 10 of this subsection in a market, the health insurance issuer may not provide for the issuance of any health insurance coverage in the market and this Commonwealth during the five-year period beginning on the date of the discontinuation of the last health insurance coverage not so renewed;

12. At the time of coverage renewal, a health insurance issuer may modify the health insurance coverage for a product offered to a group health plan or health insurance issuer offering group health insurance coverage in the group market if, for coverage that is available in such market other than only through one or more bona fide associations, such modification is consistent with the laws of this Commonwealth and effective on a uniform basis among group health plans or health insurance issuers offering group health insurance coverage with that product; *or*

13. In applying this section in the case of health insurance coverage that is made available by a health insurance issuer in the group market to employers only through one or more associations, a reference to "plan sponsor" is deemed, with respect to coverage provided to an employer member of the association, to include a reference to such employer~~; or~~

~~14. Benefits and premiums which have been added by rider to the essential or standard benefit plans issued to small employers shall be renewable at the sole option of the health insurance issuer~~.

B. If coverage to the small employer market pursuant to this article ceases to be written, administered or otherwise provided, such coverage shall continue to be governed by this article with respect to business conducted under this article that was transacted prior to the effective date of termination and that remains in force.

§ 38.2-3432.2. Availability.

A. If coverage is offered under this article in the small employer market:

1. Such coverage shall be offered and made available to all the eligible employees of every small employer and their dependents, including late enrollees, that apply for such coverage. No coverage may be offered only to certain eligible employees or their dependents and no employees or their dependents may be excluded or charged additional premiums because of health status; and

2. All products that are approved for sale in the small group market that the health insurance issuer is actively marketing must be offered to all small employers, and the health insurance issuer must accept any employer that applies for any of those products. This subdivision shall not apply to health insurance coverage or products offered by a health insurance issuer if such coverage or product is made available in the small group market only through one or more bona fide associations.

B. No coverage offered under this article shall exclude an employer based solely on the nature of the employer's business.

C. A health insurance issuer that offers health insurance coverage in a small group market through a network plan may:

1. Limit the employers that may apply for such coverage to those eligible individuals who live, work or reside in the service area for such network plan; and

2. Within the service area of such plan, deny such coverage to such employers if the health insurance issuer has demonstrated, if required, to the satisfaction of the Commission that:

a. It will not have the capacity to deliver services adequately to enrollees of any additional groups because of its obligations to existing group contract holders and enrollees; and

b. It is applying this subdivision uniformly to all employers without regard to the claims experience

of those employers and their employees (and their dependents) or any health status-related factors relating to such employees and dependents.

3. A health insurance issuer upon denying health insurance coverage in any service area in accordance with subdivision D 1, may not offer coverage in the small group market within such service area for a period of 180 days after the date such coverage is denied.

D. A health insurance issuer may deny health insurance coverage in the small group market if the health insurance issuer has demonstrated, if required, to the satisfaction of the Commission that:

1. It does not have the financial reserves necessary to underwrite additional coverage; and

2. It is applying this subdivision uniformly to all employers in the small group market in the Commonwealth consistent with the laws of this Commonwealth and without regard to the claims experience of those employers and their employees (and their dependents) or any health status-related factor relating to such employees and dependents.

E. A health insurance issuer upon denying health insurance coverage in accordance with subsection D in the Commonwealth may not offer coverage in the small group market for a period of 180 days after the date such coverage is denied or until the health insurance issuer has demonstrated to the satisfaction of the Commission that the health insurance issuer has sufficient financial reserves to underwrite additional coverage, whichever is later.

F. Nothing in this article shall be construed to preclude a health insurance issuer from establishing employer contribution rules or group participation rules in connection with a health benefit plan offered in the small group market. As used in this article, the term "employer contribution rule" means a requirement relating to the minimum level or amount of employer contribution toward the premium for enrollment of eligible individuals and the term "group participation rule" means a requirement relating to the minimum number of eligible employees that must be enrolled in relation to a specified percentage or number of eligible employees. Any employer contribution rule or group participation rule shall be applied uniformly among small employers without reference to the size of the small employer group, health status of the small employer group, or other factors.

G. The provisions of this section shall not apply in any instance in which the provisions of this section are inconsistent or in conflict with a provision of Article 6 (§ 38.2-3438 et seq.) of Chapter 34.

§ 38.2-3436. Eligibility to enroll.

A. A health insurance issuer offering group health insurance coverage, may not establish rules for eligibility (including continued eligibility) of any individual to enroll under the terms of the plan based on any of the health status-related factors.

B. The provisions of this section shall not be construed:

1. To require a group health insurance coverage to provide particular benefits other than those provided under the terms of such plan or coverage; or

2. To prevent a health insurance issuer offering group health insurance coverage from establishing limitations or restrictions on the amount, level, extent or nature of the benefits or coverage for similarly situated individuals enrolled in the plan or coverage rules for eligibility to enroll under a plan which includes rules defining any applicable waiting periods for such enrollment.

C. A health insurance issuer offering group health insurance coverage, may not require an individual (as a condition of enrollment or continued enrollment under the plan) to pay a premium or contribution which is greater than such premium or contribution for a similarly situated individual enrolled in the plan on the basis of any health status related factor in relation to the individual or to an individual enrolled under the plan as a dependent of the individual.

D. Nothing in subsection C shall be construed:

1. To restrict the amount that an employee may be charged for coverage under a group health plan or group health insurance coverage; or

2. To prevent a health insurance issuer offering group health insurance coverage, from establishing premium discounts or rebates or modifying otherwise applicable copayments or deductibles in return for adherence to programs of health promotion and disease prevention.

E. The provisions of this section shall not apply in any instance in which the provisions of this section are inconsistent or in conflict with a provision of Article 6 (§ 38.2-3438 et seq.) of Chapter 34.

§ 38.2-3438. Definitions.

As used this article, unless the context requires a different meaning:

"Child" means a son, daughter, stepchild, adopted child, including a child placed for adoption, foster child or any other child eligible for coverage under the health benefit plan.

"Covered benefits" or "benefits" means those health care services to which an individual is entitled under the terms of a health benefit plan.

"Covered person" means a policyholder, subscriber, enrollee, participant, or other individual covered by a health benefit plan.

"Dependent" means the spouse or child of an eligible employee, subject to the applicable terms of

the policy, contract, or plan covering the eligible employee.

"Emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in (i) serious jeopardy to the mental or physical health of the individual, (ii) danger of serious impairment to bodily functions, (iii) serious dysfunction of any bodily organ or part, or (iv) in the case of a pregnant woman, serious jeopardy to the health of the fetus.

"Emergency services" means with respect to an emergency medical condition: (i) a medical screening examination as required under § 1867 of the Social Security Act (42 U.S.C. § 1395dd) that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition and (ii) such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the hospital, as are required under § 1867 of the Social Security Act (42 U.S.C. § 1395dd(e)(3)) to stabilize the patient.

"ERISA" means the Employee Retirement Income Security Act of 1974.

"Essential health benefits" include the following general categories and the items and services covered within the categories in accordance with regulations issued pursuant to the PPACA: (i) ambulatory patient services; (ii) emergency services; (iii) hospitalization; (iv) laboratory services; (v) maternity and newborn care; (vi) mental health and substance abuse disorder services, including behavioral health treatment; (vii) pediatric services, including oral and vision care; (viii) prescription drugs; (ix) preventive and wellness services and chronic disease management; and (x) rehabilitative and habilitative services and devices.

"Facility" means an institution providing health care related services or a health care setting, including but not limited to hospitals and other licensed inpatient centers; ambulatory surgical or treatment centers; skilled nursing centers; residential treatment centers; diagnostic, laboratory, and imaging centers; and rehabilitation and other therapeutic health settings.

"Genetic information" means, with respect to an individual, information about: (i) the individual's genetic tests; (ii) the genetic tests of the individual's family members; (iii) the manifestation of a disease or disorder in family members of the individual; or (iv) any request for, or receipt of, genetic services, or participation in clinical research that includes genetic services, by the individual or any family member of the individual. "Genetic information" does not include information about the sex or age of any individual. As used in this definition, "family member" includes a first-degree, second-degree, third-degree, or fourth-degree relative of a covered person.

"Genetic services" means (i) a genetic test; (ii) genetic counseling, including obtaining, interpreting, or assessing genetic information; or (iii) genetic education.

"Genetic test" means an analysis of human DNA, RNA, chromosomes, proteins, or metabolites, if the analysis detects genotypes, mutations, or chromosomal changes. "Genetic test" does not include an analysis of proteins or metabolites that is directly related to a manifested disease, disorder, or pathological condition.

"Grandfathered plan" means coverage provided by a health carrier ~~in which~~ *to (i) a small employer on March 23, 2010, or (ii)* an individual *that* was enrolled on March 23, 2010, *including any extension of coverage to an individual who becomes a dependent of a grandfathered enrollee after March 23, 2010,* for as long as such plan maintains that status in accordance with federal law.

"Group health insurance coverage" means health insurance coverage offered in connection with a group health benefit plan.

"Group health plan" means an employee welfare benefit plan as defined in § 3(1) of ERISA to the extent that the plan provides medical care within the meaning of § 733(a) of ERISA to employees, including both current and former employees, or their dependents as defined under the terms of the plan directly or through insurance, reimbursement, or otherwise.

"Health benefit plan" means a policy, contract, certificate, or agreement offered by a health carrier to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services. "Health benefit plan" includes short-term and catastrophic health insurance policies, and a policy that pays on a cost-incurred basis, except as otherwise specifically exempted in this definition. "Health benefit plan" does not include the "excepted benefits" as defined in § 38.2-3431.

"Health care professional" means a physician or other health care practitioner licensed, accredited, or certified to perform specified health care services consistent with state law.

"Health care provider" or "provider" means a health care professional or facility.

"Health care services" means services for the diagnosis, prevention, treatment, cure, or relief of a health condition, illness, injury, or disease.

"Health carrier" means an entity subject to the insurance laws and regulations of the Commonwealth and subject to the jurisdiction of the Commission that contracts or offers to contract to provide, deliver,

arrange for, pay for, or reimburse any of the costs of health care services, including an insurer licensed to sell accident and sickness insurance, a health maintenance organization, a health services plan, or any other entity providing a plan of health insurance, health benefits, or health care services.

"Health maintenance organization" means a person licensed pursuant to Chapter 43 (§ 38.2-4300 et seq.).

"Health status-related factor" means any of the following factors: health status; medical condition, including physical and mental illnesses; claims experience; receipt of health care services; medical history; genetic information; evidence of insurability, including conditions arising out of acts of domestic violence; disability; or any other health status-related factor as determined by federal regulation.

"Individual health insurance coverage" means health insurance coverage offered to individuals in the individual market, which includes a health benefit plan provided to individuals through a trust arrangement, association, or other discretionary group that is not an employer plan, but does not include coverage defined as "excepted benefits" in § 38.2-3431 or short-term limited duration insurance. *Student health insurance coverage shall be considered a type of individual health insurance coverage.* A health carrier offering health insurance coverage in connection with a group health plan shall not be deemed to be a health carrier offering individual health insurance coverage solely because the carrier offers a conversion policy.

"Individual market" means the market for health insurance coverage offered to individuals other than in connection with a group health ~~benefit~~ plan.

"Managed care plan" means a health benefit plan that either requires a covered person to use, or creates incentives, including financial incentives, for a covered person to use health care providers managed, owned, under contract with, or employed by the health carrier.

"Network" means the group of participating providers providing services to a managed care plan.

"Open enrollment" means, with respect to individual health insurance coverage, the period of time during which any individual ~~under the age of 19~~ has the opportunity to apply for coverage under a health benefit plan offered by a health carrier and must be accepted for coverage under the plan without regard to a preexisting condition exclusion.

"Participating health care professional" means a health care professional who, under contract with the health carrier or with its contractor or subcontractor, has agreed to provide health care services to covered persons with an expectation of receiving payments, other than coinsurance, copayments, or deductibles, directly or indirectly from the health carrier.

"PPACA" means the Patient Protection and Affordable Care Act (P.L. 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152), and as it may be further amended.

"Preexisting condition exclusion" means a limitation or exclusion of benefits, including a denial of coverage, based on the fact that the condition was present before the effective date of coverage, or if the coverage is denied, the date of denial, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before the effective date of coverage. "Preexisting condition exclusion" also includes a condition identified as a result of a pre-enrollment questionnaire or physical examination given to an individual, or review of medical records relating to the pre-enrollment period.

"Premium" means all moneys paid by an employer, eligible employee, or covered person as a condition of coverage from a health carrier, including fees and other contributions associated with the health benefit plan.

"Primary care health care professional" means a health care professional designated by a covered person to supervise, coordinate, or provide initial care or continuing care to the covered person and who may be required by the health carrier to initiate a referral for specialty care and maintain supervision of health care services rendered to the covered person.

"Rescission" means a cancellation or discontinuance of coverage under a health benefit plan that has a retroactive effect. "Rescission" does not include:

1. A cancellation or discontinuance of coverage under a health benefit plan if the cancellation or discontinuance of coverage has only a prospective effect, or the cancellation or discontinuance of coverage is effective retroactively to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage; or

2. A cancellation or discontinuance of coverage when the health benefit plan covers active employees and, if applicable, dependents and those covered under continuation coverage provisions, if the employee pays no premiums for coverage after termination of employment and the cancellation or discontinuance of coverage is effective retroactively back to the date of termination of employment due to a delay in administrative recordkeeping.

"Stabilize" means with respect to an emergency medical condition, to provide such medical treatment as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility, or,

with respect to a pregnant woman, that the woman has delivered, including the placenta.

"Student health insurance coverage" means a type of individual health insurance coverage that is provided pursuant to a written agreement between an institution of higher education, as defined by the Higher Education Act of 1965, and a health carrier and provided to students enrolled in that institution of higher education and their dependents, and that does not make health insurance coverage available other than in connection with enrollment as a student, or as a dependent of a student, in the institution of higher education, and does not condition eligibility for health insurance coverage on any health status-related factor related to a student or a dependent of the student.

"Wellness program" means a program offered by an employer that is designed to promote health or prevent disease.

§ 38.2-3439. Dependent coverage for individuals to age 26.

A. Notwithstanding any provision of § 38.2-3500 or 38.2-3525, or any other section of this title to the contrary, a health carrier that makes available dependent coverage for a child shall make that coverage available for a child until such child attains the age of 26.

1. A health carrier shall not define "dependent" for purposes of eligibility for dependent coverage for a child other than in terms of a relationship between a child and the covered person.

2. A health carrier shall not deny or restrict coverage for a child who has not attained the age of 26 based on the presence or absence of the child's financial dependency on the covered person, residency with the covered person, marital status, student status, employment, or any combination of those factors.

3. Nothing in this section shall be construed to require a health carrier to make coverage available for the child of a child receiving dependent coverage, unless the grandparent becomes the legal guardian or adoptive parent of that grandchild.

4. The terms of coverage in a health benefit plan offered by a health carrier providing dependent coverage may not vary based on age except for children who are 26 years of age or older.

5. A health carrier shall not deny or restrict coverage of a child based on eligibility for other coverage.

B. Any child whose coverage ended, who was denied coverage, or who was not eligible for group or individual health insurance coverage under a health benefit plan because, under the terms of such plan, the availability of dependent coverage of a child ended before the attainment of the age of 26, shall be given written notice of the opportunity to enroll. The child shall be offered all the benefit packages available to, and shall not be required to pay more for coverage than, similarly situated individuals who did not lose coverage by reason of cessation of dependent status.

1. The health carrier shall give such child written notice of the opportunity to enroll not later than the first day of the next plan year or policy year, and shall provide for an enrollment period that continues for at least 30 days.

2. The written notice of opportunity to enroll shall include a statement that a child is eligible to enroll in dependent coverage if coverage ended, coverage was denied, or the child was ineligible for coverage because the availability of dependent coverage for a child ended before the attainment of the age of 26.

a. The notice may be provided to the covered person on behalf of the covered person's child.

b. For group health insurance coverage, the notice may be included with other enrollment materials that the health carrier distributes to employees, provided the statement is prominent.

3. For any child of a covered person who enrolls, the coverage shall take effect not later than the first day of such plan year or policy year.

C. This section shall apply to any health carrier providing individual or group health insurance coverage, except that for plan years beginning before January 1, 2014, a grandfathered group health plan that makes available dependent coverage for a child may exclude a child who has not attained the age of 26 from coverage only if the child is eligible to enroll in an eligible employer-sponsored health benefit plan, as defined in § 5000A(f)(2) of the Internal Revenue Code, other than the group health plan of a parent.

For plan years beginning on or after January 1, 2014, any grandfathered plan shall comply with the requirements of subsections A and B.

§ 38.2-3440. Lifetime and annual limits.

A. Notwithstanding any provision of § 38.2-3406.1, 38.2-3406.2, or 38.2-3418.5, or any other section of this title to the contrary, a health carrier offering group or individual health insurance coverage shall not establish a lifetime limit on the dollar amount of essential health benefits for any covered person.

B. ~~Beginning on January 1, 2014, a~~ *A* health carrier shall not establish any annual limit on the dollar amount of essential health benefits for any covered person.

~~C. For a plan or policy year beginning prior to January 1, 2014, a health benefit plan may establish an annual limit on the dollar amount of essential health benefits for any covered person, provided the limit is no less than the following:~~

~~1. For a plan or policy year beginning after September 22, 2010, but before September 23, 2011, $750,000;~~

~~2. For a plan or policy year beginning after September 22, 2011, but before September 23, 2012, $1.25 million; and~~

~~3. For a plan or policy year beginning after September 22, 2012, but before January 1, 2014, $2 million.~~

~~D.~~ *C.* The provisions of this section shall not prevent a health carrier from placing annual or lifetime dollar limits for any covered person on specific covered benefits that are not essential health benefits to the extent that such limits are otherwise permitted under applicable federal or state law.

~~E. For a plan or policy year beginning prior to January 1, 2014, a health benefit plan is exempt from the annual limit requirements if the plan is approved for a waiver from such requirements by the U.S. Department of Health and Human Services, but such exemption only applies for the specified period of time that the waiver is applicable.~~

~~1. If a health benefit plan receives a waiver from the U.S. Department of Health and Human Services, the health carrier shall notify prospective applicants and affected policyholders and the Commission within 30 days of receipt of the waiver.~~

~~2. Within 30 days of when the waiver expires or is otherwise no longer in effect, the health carrier shall notify affected policyholders.~~

~~F. If an individual's benefits under a health benefit plan ended by reason of reaching a lifetime limit on the dollar amount of benefits, the health carrier shall provide such individual written notice that the lifetime limit on the dollar value of benefits no longer applies; and the individual, if still eligible to be covered under the plan, may be reinstated to receive benefits under the plan.~~

~~1. If the individual is not enrolled in the plan, or if an enrolled individual is eligible for any other benefit package offered under the plan, the health benefit plan shall provide an opportunity for the individual to enroll in any benefit packages offered under the plan for a period of at least 30 days.~~

~~2. For individual health insurance coverage, an individual is not entitled to reinstatement under the health benefit plan if the individual reached his lifetime limit and the contract is not renewed or is otherwise no longer in effect. Reinstatement shall apply to a family member who reached his lifetime limit in a family plan and other family members remain covered under the plan.~~

~~3. The notice and enrollment opportunity under this subsection shall be provided beginning not later than the first day of the next plan year or policy year.~~

~~4. The required notice shall be provided to a covered person, or the covered person on behalf of his dependent. For group health insurance coverage, the notice may be included with other enrollment materials that a health carrier distributes to employees, provided the notice is prominently presented with such materials.~~

~~5. Reinstatement shall occur not later than the first day of such plan year or policy year.~~

~~G.~~ *D.* This section shall apply to any health carrier providing individual or group health insurance coverage, except that the prohibition and limits on annual limits shall not apply to a grandfathered plan providing individual health insurance coverage.

§ 38.2-3442. Preventive services.

A. Notwithstanding any provision of § 38.2-3406.1, 38.2-3411.1, or any other section of this title to the contrary, a health carrier shall provide coverage for all of the following items and services, and shall not impose any cost-sharing requirements such as a copayment, coinsurance, or deductible with respect to the following items and services:

1. Evidence-based items or services that have in effect a rating of A or B in the recommendations of the U.S. Preventive Services Task Force ~~as of September 23, 2010~~, with respect to the individual involved;

2. Immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved. For purposes of this subdivision, a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention is considered in effect after it has been adopted by the Director of the Centers for Disease Control and Prevention, and a recommendation is considered to be for routine use if it is listed on the Immunization Schedules of the Centers for Disease Control and Prevention;

3. With respect to infants, children, and adolescents, evidence-informed preventive care and screenings ~~in the Recommendations for Preventive Pediatric Health by the American Academy of Pediatrics and the Recommended Uniform Screening Panels by the Secretary's Advisory Committee on Heritable Disorders in Newborns and Children~~ *provided for in comprehensive guidelines supported by the Health Resources and Services Administration*; and

4. With respect to women, evidence-informed preventive care and screenings recommended in comprehensive guidelines supported by the Health Resources and Services Administration.

B. A health carrier is not required to provide coverage for any items or services specified in any recommendation or guideline described in subsection A after the recommendation or guideline is no longer in effect.

C. A health carrier shall at least annually at the beginning of each new plan year or policy year revise the preventive services covered under its health benefit plans pursuant to this section consistent with the most current recommendations of the U.S. Preventive Services Task Force, the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, and the guidelines with respect to infants, children, adolescents, and women evidence-based preventive care and screenings by the Health Resources and Services Administration in effect at the time.

D. 1. A health carrier may impose cost-sharing requirements with respect to an office visit if an item or service is billed separately or is tracked as individual encounter data separately from the office visit.

2. A health carrier shall not impose cost-sharing requirements with respect to an office visit if an item or service is not billed separately or is not tracked as individual encounter data separately from the office visit and the primary purpose of the office visit is the delivery of the item or service.

3. A health carrier may impose cost-sharing requirements with respect to an office visit if an item or service is not billed separately or is not tracked as individual encounter data separately from the office visit and the primary purpose of the office visit is not the delivery of the item or service.

E. Nothing in this section shall preclude a health carrier that has a network of providers from imposing cost-sharing requirements for items or services that are delivered by an out-of-network provider.

F. This section shall apply to any health carrier providing individual or group health insurance coverage, except for any grandfathered plan.

§ 38.2-3444. Preexisting condition exclusions.

A. Notwithstanding any provision of § *38.2-508.1,* 38.2-3432.3, *38.2-3438, 38.2-3503, 38.2-3520,* 38.2-4216.1, or any other section of this title to the contrary, a health carrier providing individual or group health insurance coverage shall not limit or exclude coverage for an individual ~~under the age of 19~~ by imposing a preexisting condition exclusion on that individual.

B. ~~Where a~~ *A* health carrier *that* offers individual health insurance coverage ~~that only covers individuals under the age of 19, such health carrier~~ may offer coverage continuously throughout the year or during an open enrollment period ~~in January and July of each calendar year~~.

~~C. During an open enrollment period, a health carrier shall not deny or unreasonably delay the issuance of a policy or refuse to issue a policy to an individual who is under the age of 19 on the basis of a preexisting condition.~~

~~D. Coverage shall be effective for an individual applying during an open enrollment period on the same basis as any applicant qualifying for coverage on an underwritten basis.~~

~~E. Each health carrier shall provide a prominent public notice on its website and written notice to each covered person at least 90 days prior to the open enrollment period of the open enrollment rights for individuals under the age of 19 and provide information as to how an individual eligible for this open enrollment right may apply for coverage with the health carrier during an open enrollment period.~~

~~F.~~ *C.* This section shall apply to any health carrier providing individual or group health insurance coverage, including a grandfathered plan for group health insurance coverage, but not including a grandfathered plan for individual health insurance coverage.

§ 38.2-3447. Restrictions relating to premium rates.

A. Notwithstanding any provision of § 38.2-3432.2, 38.2-3501, 38.2-4306, or any other section of this title to the contrary, a health carrier offering a health benefit plan providing individual or small group health insurance coverage shall develop its premium rates based on the following:

1. Whether the health benefit plan covers an individual or family;

2. Rating areas, as may be established by the Commission;

3. Age, except that the rate shall not vary by more than 3 to 1 for adults; and

4. Tobacco use, except that the rate shall not vary by more than 1.5 to 1.

B. A premium rate shall not vary with respect to any particular health benefit plan by any other factor not described in subsection A.

C. Rating variations for family coverage shall be applied based on the portion of the premium that is attributable to each family member covered under the health benefit plan.

§ 38.2-3448. Guaranteed availability.

A. Notwithstanding any provision of § 38.2-3430.3, 38.2-3436, or any other section of this title to the contrary, a health carrier offering a health benefit plan providing individual or group health insurance coverage shall issue such coverage to any eligible individual or employer in the Commonwealth that applies for such coverage. For purposes of this section, an "eligible individual" means any individual eligible for either individual or group health insurance coverage in the Commonwealth.

B. A health carrier may restrict enrollment in a health benefit plan to open or special enrollment

periods. The Commission may establish open enrollment periods applicable to all health benefit plans.

§ 38.2-3449. Prohibiting discrimination based on health status.

A. Notwithstanding any provision of § 38.2-508.5, 38.2-3431, 38.2-3432.3, 38.2-3521.1, 38.2-3522.1, 38.2-3540.2, 38.2-3551, 38.2-4109, or any other section of this title to the contrary, a health carrier offering a health benefit plan providing individual or group health insurance coverage shall not establish rules for eligibility, including continued eligibility, of any covered person to enroll under the terms of coverage based on any health status-related factor in relation to the covered person.

B. A health carrier shall not require any covered person as a condition of enrollment or continued enrollment under a health benefit plan to pay a premium or contribution that is greater than such premium or contribution for a similarly situated covered person enrolled in the plan on the basis of any health status-related factor in relation to the covered person.

§ 38.2-3450. Genetic information and testing.

A. A health carrier offering a health benefit plan providing individual and group health insurance coverage shall not adjust premium or contribution amounts for a covered person under such plan on the basis of genetic information.

B. A health carrier shall not request or require a covered person to undergo a genetic test, or require or purchase genetic information for underwriting purposes. A health carrier shall not request, require, or purchase genetic information with respect to any covered person prior to the covered person's enrollment under the health benefit plan.

C. Genetic information may be obtained under the following circumstances:

1. A health care professional who is providing health care services to a covered person may request that the covered person undergo a genetic test.

a. A health carrier may obtain and use the results of a genetic test in making a determination regarding payment of a claim.

b. A health carrier may request only the minimum amount of information necessary to accomplish the intended purpose.

2. A health carrier may request, but not require, that a covered person undergo a genetic test if all of the following conditions are met:

a. The request is made pursuant to research that complies with Part 46 of Title 45 of the Code of Federal Regulations or equivalent federal regulations and any applicable state or local law or regulation for the protection of human subjects in research;

b. The health carrier clearly indicates to the covered person, or in the case of a minor child, to the legal guardian of the child, to whom the request is made that:

(1) Compliance with the request is voluntary; and

(2) Noncompliance will have no effect on enrollment status or premium or contribution amounts;

c. No genetic information collected or acquired under this subsection shall be used for underwriting purposes;

d. The health carrier notifies the federal Secretary of Health and Human Services in writing that the health carrier is conducting activities pursuant to the exception provided in this subsection, including a description of all the activities conducted; and

e. The health carrier complies with such other conditions as the Secretary may by regulation require for activities conducted under this subsection.

D. Any reference in this section to genetic information concerning a covered person shall:

1. With respect to the covered person who is a pregnant woman, include genetic information of any fetus carried by the pregnant woman; and

2. With respect to a covered person utilizing an assisted reproductive technology, include genetic information of any embryo legally held by the covered person.

E. This section shall apply to any health carrier providing individual or group health insurance coverage, including any grandfathered plan.

§ 38.2-3451. Essential health benefits.

Notwithstanding any provision of § 38.2-3431 or any other section of this title to the contrary, a health carrier offering a health benefit plan providing individual or small group health insurance coverage shall provide that such coverage includes the essential health benefits as required by § 1302(a) of the PPACA. The essential health benefits package may also include associated cost-sharing requirements or limitations.

§ 38.2-3452. Waiting periods.

Notwithstanding any provision of § 38.2-3436, 38.2-4216.1, or any other section of this title to the contrary, a health carrier offering a health benefit plan providing group health insurance coverage shall not apply any waiting period that exceeds 90 days.

§ 38.2-3453. Clinical trials.

A. Notwithstanding any provision of § 38.2-3418.8 or any other section of this title to the contrary, if

a health carrier offering a health benefit plan providing individual or group health insurance coverage provides coverage to a qualified individual, then such plan shall provide for participation in an approved clinical trial and cover routine patient costs for items and services furnished in connection with participation in such clinical trial. The health carrier shall not discriminate against the qualified individual on the basis of his participation in such clinical trial.

B. For purposes of this section:

1. "Approved clinical trial" means a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition, and the study or investigation is (i) a federally funded or approved trial, (ii) conducted under an investigational new drug application reviewed by the U.S. Food and Drug Administration, or (iii) a drug trial that is exempt from having an investigational new drug application.

2. "Life threatening condition" means any disease or condition from which the likelihood of death is probable unless the course of disease or condition is interrupted.

3. "Qualified individual" means a covered person who is eligible to participate in an approved clinical trial according to the trial protocol, with respect to treatment of cancer or other life-threatening disease or condition, and the referring health care professional has concluded that the individual's participation in such trial is appropriate to treat the disease or condition, or the individual's participation is based on medical and scientific information.

4. "Routine patient costs" means all items and services consistent with the coverage provided under the health benefit plan that is typically covered for a qualified individual who is not enrolled in a clinical trial. Routine patient costs do not include the investigational item, device, or service itself; items or services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

C. Nothing in this section shall preclude a health benefit plan from requiring that a qualified individual participate in an approved clinical trial through a participating provider if such provider will accept the individual as a participant in the trial. However, a health benefit plan may not preclude a qualified individual from participating in an approved clinical trial conducted outside the state in which the individual resides.

This section shall not be construed to require that a health benefit plan provide benefits outside of the plan's health care provider network unless out-of-network benefits are otherwise provided under the plan.

D. This section shall not apply to any grandfathered plan providing individual or group health insurance coverage.

§ 38.2-3454. Wellness programs.

A. A health carrier offering a health benefit plan providing group health insurance coverage may provide for a wellness program if such program is made available to all similarly situated individuals. A wellness program may include:

1. A program that reimburses all or part of the cost for membership to a fitness center;

2. A diagnostic testing program that provides a reward for participation and does not base any part of the reward on outcomes;

3. A program that encourages preventive care related to a health condition through the waiver of the copayment or deductible requirement under a group health plan for the cost of certain items or services related to a health condition, such as prenatal care or well-baby visits;

4. A program that reimburses individuals for the cost of smoking cessation programs without regard to whether the individual quits smoking; or

5. A program that provides a reward to individuals for attending a periodic health education seminar.

B. Notwithstanding any provision of § 38.2-3449, 38.2-3540.2, or any other section of this title to the contrary, a health carrier offering a health benefit plan providing group health insurance coverage shall not create conditions for obtaining a premium discount or rebate or other reward for participation in a wellness program that is based on an individual satisfying a standard related to a health status factor, except in instances where the following requirements are satisfied:

1. The reward for the wellness program, together with the reward for other wellness programs with respect to the plan that requires satisfaction of a standard related to a health status factor, does not exceed 30 percent of the cost of employee-only coverage. If, in addition to employees or individuals, any class of dependents may participate fully in the wellness program, such reward shall not exceed 30 percent of the cost of the coverage in which any employee or individual and any dependents are enrolled;

2. The wellness program is reasonably designed to promote health or prevent disease;

3. The health carrier gives individuals eligible for the program the opportunity to qualify for the

reward under the program at least once each year;

4. The full reward under the wellness program is made available to all similarly situated individuals. The reward is not available to all similarly situated individuals for a period unless the wellness program allows for a reasonable alternative standard or waiver of the otherwise applicable standard for obtaining the reward for any individual for whom, for that period, (i) it is unreasonably difficult due to a medical condition to satisfy the otherwise applicable standard or (ii) it is medically inadvisable to attempt to satisfy the otherwise applicable standard. The health carrier may seek verification, such as a statement from an individual's physician, that a health status factor makes it unreasonably difficult or medically inadvisable for the individual to satisfy or attempt to satisfy the otherwise applicable standard; and

5. The health carrier discloses, in all health benefit plan materials describing the terms of the wellness program, the availability of a reasonable alternative standard or the possibility of waiver of the otherwise applicable standard required under subdivision 4. If plan materials disclose that such a program is available without describing its terms, the disclosure under this subdivision shall not be required.

§ 38.2-3501. Policy forms; powers of Commission.

A. Individual accident and sickness insurance policy forms and the rate manuals showing rules and classification of risks applicable to individual accident and sickness insurance policy forms shall be subject to the provisions of § 38.2-316. The Commission, subject to § 38.2-316, may disapprove or withdraw approval of any such policy form if it finds that the benefits provided in the policy form are or are likely to be unreasonable in relation to the premium charged. If the Commission disapproves a policy form or withdraws approval of a form, an insurer may proceed as indicated in § 38.2-1926.

B. The provisions of this section shall not apply in any instance in which the provisions of this section are inconsistent or in conflict with a provision of Article 6 (§ 38.2-3438 et seq.) of Chapter 34.

§ 38.2-3503. Required accident and sickness policy provisions.

A. Except as provided in § 38.2-3505, each individual accident and sickness insurance policy delivered or issued for delivery in this Commonwealth shall contain the provisions specified in this section using the same words which appear in this section. Provisions 1 through 12 shall apply to all such policies. In addition, provision 13 shall apply to all such policies that are delivered, issued for delivery, renewed, or extended in this Commonwealth on or after January 1, 2001. An insurer may substitute corresponding provisions of different wording approved by the Commission that are in each instance not less favorable in any respect to the insured or the beneficiary. These provisions shall be preceded individually by the caption "REQUIRED PROVISIONS" or by such appropriate individual or group captions or subcaptions as the Commission may approve.

1. Provision 1:

ENTIRE CONTRACT; CHANGES: This policy, including the endorsements and the attached papers, if any, constitutes the entire contract of insurance. No change in this policy shall be valid until approved by an executive officer of the Company and unless such approval is endorsed hereon or attached hereto. No agent has authority to change this policy or to waive any of its provisions.

2. Provision 2:

TIME LIMIT ON CERTAIN DEFENSES: (a) Misstatements in the application: After two years from the date of this policy, only fraudulent misstatements in the application may be used to void the policy or deny any claim for loss incurred or disability (as defined in the policy) that starts after the two-year period.

Provision 2 shall not be construed to affect any legal requirement for avoidance of a policy or denial of a claim during such initial two-year period, nor to limit the application of subdivisions 1, 2, 3, 4, and 5 of § 38.2-3504 in the event of misstatement with respect to age, occupation or other insurance.

Instead of Provision 2, a policy which the insured has the right to continue in force subject to its terms by the timely payment of premium (i) until at least age 50 or, (ii) for a policy issued after age 44, for at least five years from its date of issue, may contain the following provision, from which the clause in parentheses may be omitted at the insurer's option:

INCONTESTABLE:

(a) Misstatements in the application: After this policy has been in force for two years during the Insured's lifetime (excluding any period during which the Insured is disabled), the Company cannot contest the statements in the application.

PREEXISTING CONDITIONS:

(b) No claim for loss incurred or disability (as defined in the policy) that starts after one year from the date of issue of this policy will be reduced or denied because a sickness or physical condition, not excluded by name or specific description before the date of loss, had existed before the effective date of coverage.

3. Provision 3:

GRACE PERIOD: This policy has a ..... day grace period. This means that if a renewal premium is not paid on or before the date it is due, it may be paid during the following ..... days. During the grace period the policy shall continue in force.

In Provision 3 a number not less than "7" for weekly premium policies, "10" for monthly premium policies and "31" for all other policies shall be inserted between the words "a" and "day," and between "following" and "days." *However, if provisions of federal law require a policy to have a grace period in excess of one month, the period of time that the policy shall continue in force during the grace period shall not be required to exceed one month from the beginning of the grace period.*

A policy that contains a cancellation provision may add, at the end of Provision 3: "subject to the right of the Company to cancel in accordance with the cancellation provision."

A policy in which the insurer reserves the right to refuse any renewal shall have, in Provision 3, the following sentence:

The grace period will not apply if, at least . . . . . days before the premium due date, the Company has delivered or has mailed to the Insured's last address shown in the Company's records written notice of the Company's intent not to renew this policy.

In the above sentence a number not less than "7" for weekly premium policies, "10" for monthly premium policies and "31" for all other policies shall be inserted between the words "least" and "days."

4. Provision 4:

REINSTATEMENT: If the renewal premium is not paid before the grace period ends, the policy will lapse. Later acceptance of the premium by the Company or by an agent authorized to accept payment, without requiring an application for reinstatement, will reinstate the policy. If the Company or its agent requires an application for reinstatement, the Insured will be given a conditional receipt for the premium. If the application is approved the policy will be reinstated as of the approval date. Lacking such approval, the policy will be reinstated on the forty-fifth day after the date of the conditional receipt unless the Company has previously written the Insured of its disapproval. The reinstated policy will cover only loss that results from an injury sustained after the date of reinstatement and sickness that starts more than 10 days after such date. In all other respects the rights of the Insured and the Company will remain the same, subject to any provisions noted or attached to the reinstated policy. Any premiums the Company accepts for a reinstatement will be applied to a period for which premiums have not been paid. No premiums will be applied to any period more than 60 days prior to the date of reinstatement.

The last sentence of Provision 4 may be omitted from any policy that the Insured has the right to continue in force subject to its terms by the timely payment of premiums (i) until at least age 50, or (ii) for a policy issued after age 44, for at least five years from its effective date.

5. Provision 5:

NOTICE OF CLAIM: Written notice of claim must be given within 20 days after a covered loss starts or as soon as reasonably possible. The notice can be given to the Company at ..... (insert the location of such office as the insurer may designate for the purpose), or to the Company's agent. Notice should include the name of the Insured, and Claimant if other than the Insured, and the policy number.

Optional paragraph: If the Insured has a disability for which benefits may be payable for at least two years, at least once in every six months after the Insured has given notice of claim, the Insured must give the Company notice that the disability has continued. The Insured need not do this if legally incapacitated. The first six months after any filing of proof by the Insured or any payment or denial of a claim by the Company will not be counted in applying this provision. If the Insured delays in giving this notice, the Insured's right to any benefits for the six months before the date the Insured gives notice will not be impaired.

6. Provision 6:

CLAIM FORMS: When the Company receives the notice of claim, it will send the Claimant forms for filing proof of loss. If these forms are not given to the Claimant within 15 days after the giving of such notice, the Claimant shall meet the proof of loss requirements by giving the Company a written statement of the nature and extent of the loss within the time limit stated in the Proofs of Loss Section.

7. Provision 7:

PROOFS OF LOSS: If the policy provides for periodic payment for a continuing loss, written proof of loss must be given the Company within 90 days after the end of each period for which the Company is liable. For any other loss, written proof must be given within 90 days after such loss. If it was not reasonably possible to give written proof in the time required, the Company shall not reduce or deny the claim for this reason if the proof is filed as soon as reasonably possible. In any event, except in the absence of legal capacity, the proof required must be given no later than one year from the time specified.

8. Provision 8:

TIME OF PAYMENT OF CLAIMS: After receiving written proof of loss, the Company will pay ..... (Insert period for payment which must not be less frequently than monthly) all benefits then

due for . . . . (Insert type of loss). Benefits for any other loss covered by this policy will be paid as soon as the Company receives proper written proof.

9. Provision 9:

PAYMENT OF CLAIMS: Benefits will be paid to the Insured. Loss of life benefits are payable in accordance with the beneficiary designation in effect at the time of payment. If none is then in effect, the benefits will be paid to the Insured's estate. Any other benefits unpaid at death may be paid, at the Company's option, either to the Insured's beneficiary or the Insured's estate.

Optional paragraph: If benefits are payable to the Insured's estate or a beneficiary who cannot execute a valid release, the Company can pay benefits up to $..... (insert an amount which shall not exceed $2,000), to someone related to the Insured or beneficiary by blood or by marriage whom the Company considers to be entitled to the benefits. The Company will be discharged to the extent of any payment made in good faith.

Optional paragraph: The Company may pay all or a portion of any indemnities provided for health care services to the health care services provider, unless the Insured directs otherwise in writing by the time proofs of loss are filed. The Company cannot require that the services be rendered by a particular health care services provider.

10. Provision 10:

PHYSICAL EXAMINATIONS AND AUTOPSY: The Company at its own expense has the right to have the Insured examined as often as reasonably necessary while a claim is pending. It may also have an autopsy made unless prohibited by law.

11. Provision 11:

LEGAL ACTIONS: No legal action may be brought to recover on this policy within 60 days after written proof of loss has been given as required by this policy. No legal action may be brought after three years from the time written proof of loss is required to be given.

12. Provision 12:

CHANGE OF BENEFICIARY: The Insured can change the beneficiary at any time by giving the Company written notice. The beneficiary's consent is not required for this or any other change in the policy, unless the designation of the beneficiary is irrevocable.

13. Provision 13:

CANCELLATION BY INSURED: The Insured may cancel this policy at any time by written notice delivered or mailed to the Company effective upon receipt or on such later date as may be specified in the notice. In the event of cancellation, the Company shall return promptly the unearned portion of any premium paid. The earned premium shall be computed pro rata. Cancellation shall be without prejudice to any claim originating prior to the effective date of cancellation.

B. The provisions of this section shall not apply in any instance in which the provisions of this section are inconsistent or in conflict with a provision of Article 6 (§ 38.2-3438 et seq.) of Chapter 34.

§ 38.2-3520. Coverage of preexisting conditions.

A. Notwithstanding the provisions of § 38.2-3503, if an insurer elects to use a simplified application form, with or without a specific question as to the applicant's health, but without any detailed questions concerning the insured's health history or medical treatment history, the policy shall cover any loss occurring after twelve months from the effective date of coverage from any preexisting condition not specifically excluded from coverage by terms of the policy. Except as so provided, the policy shall not include wording that would permit a defense based upon preexisting conditions.

B. The provisions of this section shall not apply in any instance in which the provisions of this section are inconsistent or in conflict with a provision of Article 6 (§ 38.2-3438 et seq.) of Chapter 34.

§ 38.2-3521.1. Group accident and sickness insurance definitions.

Except as provided in § 38.2-3522.1, no policy of group accident and sickness insurance shall be delivered in this Commonwealth unless it conforms to one of the following descriptions:

A. A policy issued to an employer, or to the trustees of a fund established by an employer, which employer or trustees shall be deemed the policyholder, to insure employees of the employer for the benefit of persons other than the employer, subject to the following requirements:

1. The employees eligible for insurance under the policy shall be all of the employees of the employer, or all of any class or classes thereof. The policy may provide that the term "employees" shall include the employees of one or more subsidiary corporations, and the employees, individual proprietors, and partners of one or more affiliated corporations, proprietorships or partnerships if the business of the employer and of such affiliated corporations, proprietorships or partnerships is under common control. The policy may provide that the term "employees" shall include retired employees, former employees and directors of a corporate employer. A policy issued to insure the employees of a public body may provide that the term "employees" shall include elected or appointed officials.

2. The premium for the policy shall be paid either from the employer's funds or from funds contributed by the insured employees, or from both. Except as provided in subdivision 3 of this

subsection, a policy on which no part of the premium is to be derived from funds contributed by the insured employees must insure all eligible employees, except those who reject such coverage in writing.

3. An insurer may exclude or limit the coverage on any person as to whom evidence of individual insurability is not satisfactory to the insurer, except as otherwise prohibited in this title.

B. A policy which is:

1. Not subject to Chapter 37.1 (§ 38.2-3727 et seq.) of this title, and

2. Issued to a creditor or its parent holding company or to a trustee or trustees or agent designated by two or more creditors, which creditor, holding company, affiliate, trustee, trustees or agent shall be deemed the policyholder, to insure debtors of the creditor or creditors with respect to their indebtedness, subject to the following requirements:

a. The debtors eligible for insurance under the policy shall be all of the debtors of the creditor or creditors, or all of any class or classes thereof. The policy may provide that the term "debtors" shall include:

(1) Borrowers of money or purchasers or lessees of goods, services, or property for which payment is arranged through a credit transaction;

(2) The debtors of one or more subsidiary corporations; and

(3) The debtors of one or more affiliated corporations, proprietorships or partnerships if the business of the policyholder and of such affiliated corporations, proprietorships or partnerships is under common control.

b. The premium for the policy shall be paid either from the creditor's funds, or from charges collected from the insured debtors, or from both. Except as provided in subdivision 3 of this subsection, a policy on which no part of the premium is to be derived from funds contributed by insured debtors specifically for their insurance must insure all eligible debtors.

3. An insurer may exclude any debtors as to whom evidence of individual insurability is not satisfactory to the insurer.

4. The total amount of insurance payable with respect to an indebtedness shall not exceed the greater of the scheduled or actual amount of unpaid indebtedness to the creditor. The insurer may exclude any payments which are delinquent on the date the debtor becomes disabled as defined in the policy.

5. The insurance may be payable to the creditor or any successor to the right, title, and interest of the creditor. Such payment or payments shall reduce or extinguish the unpaid indebtedness of the debtor to the extent of each such payment and any excess of the insurance shall be payable to the insured or the estate of the insured.

6. Notwithstanding the preceding provisions of this section, insurance on agricultural credit transaction commitments may be written up to the amount of the loan commitment. Insurance on educational credit transaction commitments may be written up to the amount of the loan commitment less the amount of any repayments made on the loan.

C. A policy issued to a labor union, or similar employee organization, which labor union or organization shall be deemed to be the policyholder, to insure members of such union or organization for the benefit of persons other than the union or organization or any of its officials, representatives, or agents, subject to the following requirements:

1. The members eligible for insurance under the policy shall be all of the members of the union or organization, or all of any class or classes thereof.

2. The premium for the policy shall be paid either from funds of the union or organization, or from funds contributed by the insured members specifically for their insurance, or from both. Except as provided in subdivision 3 of this subsection, a policy on which no part of the premium is to be derived from funds contributed by the insured members specifically for their insurance must insure all eligible members, except those who reject such coverage in writing.

3. An insurer may exclude or limit the coverage on any person as to whom evidence of individual insurability is not satisfactory to the insurer, except as otherwise prohibited in this title.

D. A policy issued (i) to or for a multiple employer welfare arrangement, a rural electric cooperative, or a rural electric telephone cooperative as these terms are defined in 29 U.S.C. § 1002, or (ii) to a trust, or to the trustees of a fund, established or adopted by or for two or more employers, or by one or more labor unions of similar employee organizations, or by one or more employers and one or more labor unions or similar employee organizations, which trust or trustees shall be deemed the policyholder, to insure employees of the employers or members of the unions or organizations for the benefit of persons other than the employers or the unions or organizations, subject to the following requirements:

1. The persons eligible for insurance shall be all of the employees of the employers or all of the members of the unions or organizations, or all of any class or classes thereof. The policy may provide that the term "employee" shall include the employees of one or more subsidiary corporations, and the employees, individual proprietors, and partners of one or more affiliated corporations, proprietorships or partnerships if the business of the employer and of such affiliated corporations, proprietorships or

partnerships is under common control. The policy may provide that the term "employees" shall include retired employees, former employees and directors of a corporate employer. The policy may provide that the term "employees" shall include the trustees or their employees, or both, if their duties are principally connected with such trusteeship.

2. The premium for the policy shall be paid from funds contributed by the employer or employers of the insured persons, or by the union or unions or similar employee organizations, or by both, or from funds contributed by the insured persons or from both the insured persons and the employers or unions or similar employee organizations. Except as provided in subdivision 3 of this subsection, a policy on which no part of the premium is to be derived from funds contributed by the insured persons specifically for their insurance must insure all eligible persons, except those who reject such coverage in writing.

3. An insurer may exclude or limit the coverage on any person as to whom evidence of individual insurability is not satisfactory to the insurer, except as otherwise prohibited in this title.

E. 1. A policy issued to an association or to a trust or to the trustees of a fund established, created, or maintained for the benefit of members of one or more associations which association or trust shall be deemed the policyholder. The association or associations shall:

a. Have at the outset a minimum of 100 persons;

b. Have been organized and maintained in good faith for purposes other than that of obtaining insurance;

c. Have been in active existence for at least five years;

d. Have a constitution and bylaws which provide that (i) the association or associations hold regular meetings not less than annually to further purposes of the members, (ii) except for credit unions, the association or associations collect dues or solicit contributions from members, and (iii) the members have voting privileges and representation on the governing board and committees;

e. Does not condition membership in the association on any health status-related factor relating to an individual (including an employee of an employer or a dependent of an employee);

f. Makes health insurance coverage offered through the association available to all members regardless of any health status-related factor relating to such members (or individuals eligible for coverage through a member);

g. Does not make health insurance coverage offered through the association available other than in connection with a member of the association; and

h. Meets such additional requirements as may be imposed under the laws of this Commonwealth.

2. The policy shall be subject to the following requirements:

a. The policy may insure members of such association or associations, employees thereof or employees of members, or one or more of the preceding or all of any class or classes thereof for the benefit of persons other than the employee's employer.

b. The premium for the policy shall be paid from funds contributed by the association or associations, or by employer members, or by both, or from funds contributed by the covered persons or from both the covered persons and the association, associations, or employer members.

3. Except as provided in subdivision 4 of this subsection, a policy on which no part of the premium is to be derived from funds contributed by the covered persons specifically for their insurance must insure all eligible persons, except those who reject such coverage in writing.

4. An insurer may exclude or limit the coverage on any person as to whom evidence of individual insurability is not satisfactory to the insurer, except as otherwise prohibited in this title.

F. A policy issued to a credit union or to a trustee or trustees or agent designated by two or more credit unions, which credit union, trustee, trustees, or agent shall be deemed the policyholder, to insure members of such credit union or credit unions for the benefit of persons other than the credit union or credit unions, trustee or trustees, or agent or any of their officials, subject to the following requirements:

1. The members eligible for insurance shall be all of the members of the credit union or credit unions, or all of any class or classes thereof.

2. The premium for the policy shall be paid by the policyholder from the credit union's funds and, except as provided in subdivision 3 of this subsection, must insure all eligible members.

3. An insurer may exclude or limit the coverage on any person as to whom evidence of individual insurability is not satisfactory to the insurer.

G. A policy issued to a health maintenance organization as provided in subsection B of § 38.2-4314.

H. The provisions of this section shall not apply in any instance in which the provisions of this section are inconsistent or in conflict with a provision of Article 6 (§ 38.2-3438 et seq.) of Chapter 34.

§ 38.2-3522.1. Limits of group accident and sickness insurance.

Group accident and sickness insurance offered to a resident of this Commonwealth under a group accident and sickness insurance policy issued to a group other than one described in § 38.2-3521.1 shall be subject to the following requirements:

A. No such group accident and sickness insurance policy shall be delivered in this Commonwealth unless the Commission finds that:

1. The issuance of such group policy is not contrary to Virginia's public policy and is in the best interest of the citizens of this Commonwealth;

2. The issuance of the group policy would result in economies of acquisition or administration; and

3. The benefits are reasonable in relation to the premiums charged.

Insurers filing policy forms seeking approval under the provisions of this subsection shall accompany the forms with a certification, signed by the officer of the company with the responsibility for forms compliance, in which the company certifies that each such policy form will be issued only where the requirements set forth in subdivisions 1 through 3 of this subsection have been met.

B. No such group accident and sickness insurance coverage may be offered in this Commonwealth by an insurer under a policy issued in another state unless this Commonwealth or another state having requirements substantially similar to those contained in subdivisions 1, 2, and 3 of subsection A has made a determination that such requirements have been met.

1. An insurer offering group accident and sickness insurance coverage in this Commonwealth under this subsection shall file a certification, signed by the officer of the company having responsibility for forms compliance, in which the company certifies that all group insurance coverage marketed to residents of this Commonwealth under policies which have not been approved by this Commonwealth will comply with the provisions of § 38.2-3521.1 or have met the requirements set forth in subdivisions A 1 through A 3 of this section, and which clearly demonstrates that the substantially similar requirements of the state in which the contract will be issued have been met. The certification shall be accompanied by documentation from such state, evidencing the determination that such requirements have been met.

2. An insurer offering group accident and sickness insurance in this Commonwealth under this subsection that is unable to provide the documentation required in subdivision 1 of this subsection shall be required to file policy forms consistent with requirements in § 38.2-316 which are imposed on policies issued in Virginia. The policy shall be required to be approved as meeting all requirements of this title prior to its being offered to residents of this Commonwealth.

C. The premium for the policy shall be paid either from the policyholder's funds or from funds contributed by the covered persons, or from both.

D. An insurer may exclude or limit the coverage on any person as to whom evidence of individual insurability is not satisfactory to the insurer, except as otherwise prohibited in this title.

E. The provisions of this section shall not apply in any instance in which the provisions of this section are inconsistent or in conflict with a provision of Article 6 (§ 38.2-3438 et seq.) of Chapter 34.

§ 38.2-3523.4. Minimum number of persons covered.

A. A group accident and sickness insurance policy shall on the issue date and at each policy anniversary date, cover at least two persons, other than spouses or minor children, unless such spouse or minor child is determined to be an eligible employee as defined in § 38.2-3431.

B. The provisions of this section shall not apply in any instance in which the provisions of this section are inconsistent or in conflict with a provision of Article 6 (§ 38.2-3438 et seq.) of Chapter 34.

§ 38.2-3540.2. Employee wellness program.

A. Each group accident and sickness insurance policy and health care plan may provide a premium discount to every employer instituting and maintaining an employee wellness program satisfying such criteria as each insurer may establish. An employer instituting and maintaining an employee wellness program in accordance with the insurer's criteria may require that any employee wishing to enroll in such program undergo a health assessment as a condition of enrollment.

B. The provisions of this section shall not apply in any instance in which the provisions of this section are inconsistent or in conflict with a provision of Article 6 (§ 38.2-3438 et seq.) of Chapter 34.

§ 38.2-3551. Definitions.

A. As used in this article:

"Eligible dependent" means an individual who may be covered as a dependent under a group health policy or policies and who is eligible, as determined by a small employer health group cooperative, for coverage as a dependent of an eligible employee under a group health policy or policies issued to or through such small employer health group cooperative.

"Eligible employee" means an employee who works for a small employer on a full-time basis, has a normal work week of 30 or more hours, has satisfied applicable waiting period requirements, and is not a part-time, temporary, or substitute employee.

"Employer-member" means a small employer participating in a small employer health group cooperative.

"Group health policy" or "policy" means a group insurance policy providing hospital, medical and surgical or major medical coverage on an expense-incurred basis, a group accident and sickness

insurance policy or subscription contract, and a group health care plan for health care services or limited health care services provided by a health maintenance organization. For the purposes of this article, a group health policy or policy shall also mean a policy or plan provided by a dental or optometric services plan, dental plan organization, and a health maintenance organization offering limited health care services as defined in § 38.2-4300.

"Health insurance issuer" or "issuer" means a company authorized to issue coverage under Article 3 (§ 38.2-3521.1 et seq.) of Chapter 35, Chapter 42 (§ 38.2-4200 et seq.), Chapter 43 (§ 38.2-4300 et seq.), Chapter 45 (§ 38.2-4500 et seq.), or Chapter 61 (§ 38.2-6100 et seq.) of this title.

"Health status-related factor" means the following in relation to the individual or a dependent eligible for coverage under a group health plan or health insurance coverage offered by a health insurance issuer:

1. Health status;
2. Medical condition, including both physical and mental illnesses;
3. Claims experience;
4. Receipt of health care;
5. Medical history;
6. Genetic information;
7. Evidence of insurability, including conditions arising out of acts of domestic violence; or
8. Disability.

"Service area" means the geographic area within which a health insurance issuer is authorized to sell a group health policy or policies.

"Small employer" means, in connection with a group health policy with respect to a calendar year and a plan year, an employer who employed an average of at least ~~two~~ *one* but not more than 50 employees on business days during the preceding calendar year and who employs at least ~~two~~ ~~employees~~ *one employee* on the first day of the plan year. *Effective January 1, 2016, "small employer" means, in connection with a group health policy with respect to a calendar year and a plan year, an employer who employed an average of at least one but not more than 100 employees on business days during the preceding calendar year and who employs at least one employee on the first day of the plan year.*

"Small employer health group cooperative" or "cooperative" means an entity authorized by its employer-members to negotiate with health insurance issuers on their behalf as to the terms, including premium rates, under which a group health policy or policies may be issued, providing coverage for the eligible employees of such employer-members and their eligible dependents.

B. The provisions of this section shall not apply in any instance in which the provisions of this section are inconsistent or in conflict with a provision of Article 6 (§ 38.2-3438 et seq.) of Chapter 34.

§ 38.2-4109. Organization of domestic society on or after October 1, 1986.

A. On or after October 1, 1986, seven or more citizens of the United States, a majority of whom are citizens of this Commonwealth, who desire to form a fraternal benefit society, may make, sign and acknowledge before some officer competent to take acknowledgement of deeds, articles of incorporation, which shall state:

1. The proposed corporate name of the society, which shall not so closely resemble the name of any other society or insurer as to be misleading or confusing;
2. The purposes for which it is being formed and the mode in which its corporate powers are to be exercised. Such purposes shall not include more liberal powers than are granted by this chapter;
3. The names and residences of the incorporators and the names, residences and official titles of all officers, trustees, directors, or other persons who are to have and exercise the general control of the management of the affairs and funds of the society for the first year or until the ensuing election at which all such officers shall be elected by the supreme governing body, which election shall be held not later than one year from the date of issuance of the permanent certificate of authority.

B. Such articles of incorporation, duly certified copies of the society's bylaws and rules, copies of all proposed forms of certificates, applications therefor, and circulars to be issued by the society and a bond conditioned upon the return to applicants of the advanced payments if the organization is not completed within one year shall be filed with the Commission, which may require any further information it deems necessary. The bond, with sureties approved by the Commission, shall be not less than $50,000 nor more than $200,000, as required by the Commission. All documents filed are to be in the English language. If the purposes of the society conform to the requirements of this chapter and all provisions of the law have been complied with, the Commission shall so certify, retain, and file the articles of incorporation and furnish the incorporators a preliminary certificate of authority authorizing the society to solicit members as hereinafter provided.

C. No preliminary certificate of authority granted under the provisions of this section shall be valid after ~~1~~ *one* year from its date or after such further period, not exceeding one year, as may be authorized by the Commission upon cause shown, unless the 500 required applicants have been secured and the

organization has been duly completed. The articles of incorporation and all other proceedings under those articles shall become void in one year from the date of the preliminary certificate of authority, or at the expiration of the extended period, unless the society has completed its organization and received a certificate of authority to do business.

D. Upon receipt of a preliminary certificate of authority from the Commission, the society may solicit members for the purpose of completing its organization, shall collect from each applicant the amount of not less than one regular monthly premium in accordance with its table of rates, and shall issue to each such applicant a receipt for the amount collected. No society shall incur any liability other than for the return of such advance premium, nor issue any certificate, nor pay, allow, or offer or promise to pay or allow, any benefit to any person until:

1. Actual bona fide applicants for benefits have been secured on not less than 500 applicants, and any necessary evidence of insurability has been furnished to and approved by the society;

2. At least ~~ten~~ *10* subordinate lodges have been established into which the 500 applicants have been admitted;

3. There has been submitted to the Commission, a list of such applicants, giving their names, addresses, date each was admitted, name and number of the subordinate lodge of which each applicant is a member, amount of benefits to be granted and their premiums; and

4. It has been shown to the Commission, by sworn statement of the treasurer, or corresponding officer of such society, that at least 500 applicants have each paid in cash at least ~~1~~ *one* regular monthly premium, which shall total at least $150,000. Advance premiums shall be held in trust during the period of organization and, if the society has not qualified for a certificate of authority within one year, such premiums shall be returned to the applicants.

E. The Commission may examine and require any further information it deems advisable. Upon presentation of satisfactory evidence that the society has complied with all the provisions of law, the Commissioner shall issue to the society a certificate of authority to that effect and that the society is authorized to do business pursuant to the provisions of this chapter. The certificate of authority shall be prima facie evidence of the existence of the society at the date of such certificate. The Commission shall cause a record of such certificate of authority to be made. A certified copy of such record shall have the same effect as the original certificate of authority.

F. Any incorporated society authorized to do business in this Commonwealth at the time this chapter becomes effective shall not be required to reincorporate.

G. The provisions of this section shall not apply in any instance in which the provisions of this section are inconsistent or in conflict with a provision of Article 6 (§ 38.2-3438 et seq.) of Chapter 34.

§ 38.2-4214. Application of certain provisions of law.

No provision of this title except this chapter and, insofar as they are not inconsistent with this chapter, §§ 38.2-200, 38.2-203, 38.2-209 through 38.2-213, 38.2-218 through 38.2-225, 38.2-230, 38.2-232, 38.2-305, 38.2-316, 38.2-322, 38.2-400, 38.2-402 through 38.2-413, 38.2-500 through 38.2-515, 38.2-600 through 38.2-620, 38.2-700 through 38.2-705, 38.2-900 through 38.2-904, 38.2-1017, 38.2-1018, 38.2-1038, 38.2-1040 through 38.2-1044, Articles 1 (§ 38.2-1300 et seq.) and 2 (§ 38.2-1306.2 et seq.) of Chapter 13, §§ 38.2-1312, 38.2-1314, 38.2-1315.1, 38.2-1317 through 38.2-1328, 38.2-1334, 38.2-1340, 38.2-1400 through 38.2-1444, 38.2-1800 through 38.2-1836, 38.2-3400, 38.2-3401, 38.2-3404, 38.2-3405, 38.2-3405.1, 38.2-3406.1, 38.2-3406.2, 38.2-3407.1 through 38.2-3407.6:1, 38.2-3407.9 through 38.2-3407.18, 38.2-3409, 38.2-3411 through 38.2-3419.1, 38.2-3430.1 through ~~38.2-3446~~ *38.2-3454*, 38.2-3501, 38.2-3502, subdivision 13 of § 38.2-3503, subdivision 8 of § 38.2-3504, §§ 38.2-3514.1, 38.2-3514.2, §§ 38.2-3516 through 38.2-3520 as they apply to Medicare supplement policies, §§ 38.2-3522.1 through 38.2-3523.4, 38.2-3525, 38.2-3540.1, 38.2-3541 through 38.2-3542, 38.2-3543.2, Article 5 (§ 38.2-3551 et seq.) of Chapter 35, Chapter 35.1 (§ 38.2-3556 et seq.), §§ 38.2-3600 through 38.2-3607, Chapter 52 (§ 38.2-5200 et seq.), Chapter 55 (§ 38.2-5500 et seq.), and Chapter 58 (§ 38.2-5800 et seq.) of this title shall apply to the operation of a plan.

§ 38.2-4306. Evidence of coverage and charges for health care services.

A. 1. Each subscriber shall be entitled to evidence of coverage under a health care plan.

2. No evidence of coverage, or amendment to it, shall be delivered or issued for delivery in this Commonwealth until a copy of the form of the evidence of coverage, or amendment to it, has been filed with and approved by the Commission, subject to the provisions of subsection C of this section. Any evidence of coverage for enrollees in the plans administered by the Department of Medical Assistance Services that provide benefits pursuant to Title XIX or Title XXI of the Social Security Act, as amended, is excluded from the provisions of this section.

3. No evidence of coverage shall contain provisions or statements which are unjust, unfair, untrue, inequitable, misleading, deceptive or misrepresentative.

4. An evidence of coverage shall contain a clear and complete statement if a contract, or a

reasonably complete summary if a certificate, of:

a. The health care services and any insurance or other benefits to which the enrollee is entitled under the health care plan;

b. Any limitations on the services, kind of services, benefits, or kind of benefits to be provided, including any deductible or copayment feature, or both;

c. Where and in what manner information is available as to how services may be obtained;

d. The total amount of payment for health care services and any indemnity or service benefits that the enrollee is obligated to pay with respect to individual contracts, or an indication whether the plan is contributory or noncontributory for group certificates;

e. A description of the health maintenance organization's method for resolving enrollee complaints. Any subsequent change may be evidenced in a separate document issued to the enrollee;

f. A list of providers and a description of the service area which shall be provided with the evidence of coverage, if such information is not given to the subscriber at the time of enrollment; and

g. Any right of subscribers covered under a group contract to convert their coverages to an individual contract issued by the health maintenance organization.

B. Pursuant to this subsection:

1. No schedule of charges or amendment to the schedule of charges for enrollee coverage for health care services may be used in conjunction with any health care plan until a copy of the schedule, or its amendment, has been filed with the Commission. Any schedule of charges or amendment to the schedule of charges for enrollees in the plans administered by the Department of Medical Assistance Services that provide benefits pursuant to Title XIX or Title XXI of the Social Security Act, as amended, is excluded from the provisions of this subsection.

2. The charges may be established for various categories of enrollees based upon sound actuarial principles, provided that charges applying to an enrollee in a group health plan shall not be individually determined based on the status of his health. A certification on the appropriateness of the charges, based upon reasonable assumptions, may be required by the Commission to be filed along with adequate supporting information. This certification shall be prepared by a qualified actuary or other qualified professional approved by the Commission.

C. The Commission shall, within a reasonable period, approve any form if the requirements of subsection A of this section are met. It shall be unlawful to issue a form until approved. If the Commission disapproves a filing, it shall notify the filer. The Commission shall specify the reasons for its disapproval in the notice. A written request for a hearing on the disapproval may be made to the Commission within 30 days after notice of the disapproval. If the Commission does not disapprove any form within 30 days of the filing of such form, it shall be deemed approved unless the filer is notified in writing that the waiting period is extended by the Commission for an additional 30 days. Filing of the form means actual receipt by the Commission.

D. The Commission may require the submission of any relevant information it considers necessary in determining whether to approve or disapprove a filing made under this section.

E. The provisions of this section shall not apply in any instance in which the provisions of this section are inconsistent or in conflict with a provision of Article 6 (§ 38.2-3438 et seq.) of Chapter 34.

§ 38.2-4319. Statutory construction and relationship to other laws.

A. No provisions of this title except this chapter and, insofar as they are not inconsistent with this chapter, §§ 38.2-100, 38.2-136, 38.2-200, 38.2-203, 38.2-209 through 38.2-213, 38.2-216, 38.2-218 through 38.2-225, 38.2-229, 38.2-232, 38.2-305, 38.2-316, 38.2-322, 38.2-400, 38.2-402 through 38.2-413, 38.2-500 through 38.2-515, 38.2-600 through 38.2-620, Chapter 9 (§ 38.2-900 et seq.), §§ 38.2-1016.1 through 38.2-1023, 38.2-1057, 38.2-1306.1, Article 2 (§ 38.2-1306.2 et seq.), § 38.2-1315.1, Articles 3.1 (§ 38.2-1316.1 et seq.), 4 (§ 38.2-1317 et seq.) and 5 (§ 38.2-1322 et seq.) of Chapter 13, Articles 1 (§ 38.2-1400 et seq.) and 2 (§ 38.2-1412 et seq.) of Chapter 14, §§ 38.2-1800 through 38.2-1836, 38.2-3401, 38.2-3405, 38.2-3405.1, 38.2-3406.1, 38.2-3407.2 through 38.2-3407.6:1, 38.2-3407.9 through 38.2-3407.18, 38.2-3411.2, 38.2-3411.3, 38.2-3411.4, 38.2-3412.1:01, 38.2-3414.1, 38.2-3418.1 through 38.2-3418.17, 38.2-3419.1, 38.2-3430.1 through ~~38.2-3446~~ *38.2-3454*, 38.2-3500, subdivision 13 of § 38.2-3503, subdivision 8 of § 38.2-3504, §§ 38.2-3514.1, 38.2-3514.2, 38.2-3522.1 through 38.2-3523.4, 38.2-3525, 38.2-3540.1, 38.2-3540.2, 38.2-3541.1, 38.2-3541.2, 38.2-3542, 38.2-3543.2, Article 5 (§ 38.2-3551 et seq.) of Chapter 35, Chapter 35.1 (§ 38.2-3556 et seq.), Chapter 52 (§ 38.2-5200 et seq.), Chapter 55 (§ 38.2-5500 et seq.), and Chapter 58 (§ 38.2-5800 et seq.) shall be applicable to any health maintenance organization granted a license under this chapter. This chapter shall not apply to an insurer or health services plan licensed and regulated in conformance with the insurance laws or Chapter 42 (§ 38.2-4200 et seq.) except with respect to the activities of its health maintenance organization.

B. For plans administered by the Department of Medical Assistance Services that provide benefits pursuant to Title XIX or Title XXI of the Social Security Act, as amended, no provisions of this title

except this chapter and, insofar as they are not inconsistent with this chapter, §§ 38.2-100, 38.2-136, 38.2-200, 38.2-203, 38.2-209 through 38.2-213, 38.2-216, 38.2-218 through 38.2-225, 38.2-229, 38.2-232, 38.2-322, 38.2-400, 38.2-402 through 38.2-413, 38.2-500 through 38.2-515, 38.2-600 through 38.2-620, Chapter 9 (§ 38.2-900 et seq.), §§ 38.2-1016.1 through 38.2-1023, 38.2-1057, 38.2-1306.1, Article 2 (§ 38.2-1306.2 et seq.), § 38.2-1315.1, Articles 3.1 (§ 38.2-1316.1 et seq.), 4 (§ 38.2-1317 et seq.) and 5 (§ 38.2-1322 et seq.) of Chapter 13, Articles 1 (§ 38.2-1400 et seq.) and 2 (§ 38.2-1412 et seq.) of Chapter 14, §§ 38.2-3401, 38.2-3405, 38.2-3407.2 through 38.2-3407.5, 38.2-3407.6, ~~and~~ 38.2-3407.6:1, 38.2-3407.9, 38.2-3407.9:01, and 38.2-3407.9:02, subdivisions F 1, F 2, and F 3 of § 38.2-3407.10, §§ 38.2-3407.11, 38.2-3407.11:3, 38.2-3407.13, 38.2-3407.13:1, 38.2-3407.14, 38.2-3411.2, 38.2-3418.1, 38.2-3418.2, 38.2-3419.1, 38.2-3430.1 through 38.2-3437, 38.2-3500, subdivision 13 of § 38.2-3503, subdivision 8 of § 38.2-3504, §§ 38.2-3514.1, 38.2-3514.2, 38.2-3522.1 through 38.2-3523.4, 38.2-3525, 38.2-3540.1, 38.2-3540.2, 38.2-3541.2, 38.2-3542, 38.2-3543.2, Chapter 52 (§ 38.2-5200 et seq.), Chapter 55 (§ 38.2-5500 et seq.), and Chapter 58 (§ 38.2-5800 et seq.) shall be applicable to any health maintenance organization granted a license under this chapter. This chapter shall not apply to an insurer or health services plan licensed and regulated in conformance with the insurance laws or Chapter 42 (§ 38.2-4200 et seq.) except with respect to the activities of its health maintenance organization.

C. Solicitation of enrollees by a licensed health maintenance organization or by its representatives shall not be construed to violate any provisions of law relating to solicitation or advertising by health professionals.

D. A licensed health maintenance organization shall not be deemed to be engaged in the unlawful practice of medicine. All health care providers associated with a health maintenance organization shall be subject to all provisions of law.

E. Notwithstanding the definition of an eligible employee as set forth in § 38.2-3431, a health maintenance organization providing health care plans pursuant to § 38.2-3431 shall not be required to offer coverage to or accept applications from an employee who does not reside within the health maintenance organization's service area.

F. For purposes of applying this section, "insurer" when used in a section cited in subsections A and B shall be construed to mean and include "health maintenance organizations" unless the section cited clearly applies to health maintenance organizations without such construction.

2. That § 38.2-3433 of the Code of Virginia is repealed.

3. That the third enactment of Chapter 788 of the Acts of Assembly of 2011 is repealed.

4. That the second enactment of Chapter 882 of the Acts of Assembly of 2011 is repealed.

5. That the provisions of this act shall become effective on January 1, 2014.