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SENATE BILL NO. 921

Offered January 14, 2009

Prefiled January 5, 2009

A BILL to amend and reenact §§ 38.2-3409, 38.2-3411, 38.2-3411.1, 38.2-3411.2, 38.2-3411.3, 38.2-3411.4, 38.2-3412.1, 38.2-3414.1, 38.2-3418, 38.2-3418.1, 38.2-3418.1:2, 38.2-3418.2, 38.2-3418.3, 38.2-3418.4, 38.2-3418.5, 38.2-3418.6, 38.2-3418.7, 38.2-3418.7:1, 38.2-3418.8, 38.2-3418.9, 38.2-3418.10, 38.2-3418.11, 38.2-3418.12, 38.2-3418.13, and 38.2-3418.14 of the Code of Virginia, relating to mandated benefits; exempt individual policies.

Patron—Reynolds

Referred to Committee on Commerce and Labor

Be it enacted by the General Assembly of Virginia:

1. That §§ 38.2-3409, 38.2-3411, 38.2-3411.1, 38.2-3411.2, 38.2-3411.3, 38.2-3411.4, 38.2-3412.1, 38.2-3414.1, 38.2-3418, 38.2-3418.1, 38.2-3418.1:2, 38.2-3418.2, 38.2-3418.3, 38.2-3418.4, 38.2-3418.5, 38.2-3418.6, 38.2-3418.7, 38.2-3418.7:1, 38.2-3418.8, 38.2-3418.9, 38.2-3418.10, 38.2-3418.11, 38.2-3418.12, 38.2-3418.13, and 38.2-3418.14 of the Code of Virginia are amended and reenacted as follows:

§ 38.2-3409. Coverage of dependent children.

A. Any group ~~or individual~~ accident and sickness insurance policy or subscription contract delivered or issued for delivery in this Commonwealth which provides that coverage of a dependent child shall terminate upon that child's attainment of a specified age, shall also provide in substance that attainment of the specified age shall not terminate the child's coverage during the continuance of the policy while the dependent child is and continues to be both: (i) incapable of self-sustaining employment by reason of mental retardation or physical handicap, and (ii) chiefly dependent upon the policyowner for support and maintenance.

B. Proof of incapacity and dependency shall be furnished to the insurer by the policyowner within thirty-one days of the child's attainment of the specified age. Subsequent proof may be required by the insurer but not more frequently than annually after the two-year period following the child's attainment of the specified age.

C. The insurer may charge an additional premium for any continuation of coverage beyond the specified age. The additional premium shall be determined by the insurer on the basis of the class of risks applicable to the child.

§ 38.2-3411. Coverage of newborn children required.

A. Each ~~individual and~~ group accident and sickness insurance policy or ~~individual and~~ group subscription contract providing coverage on an expense incurred basis that provides coverage for a family member of the insured or the subscriber shall, as to the family members' coverage, also provide that the accident and sickness insurance benefits applicable for children shall be payable with respect to a newly born child of the insured or subscriber from the moment of birth.

B. Coverage for newly born children shall be identical to coverage provided to the insured or subscriber, except that, regardless of whether such coverage would otherwise be provided under the terms and conditions of the insurance policy or subscription contract, coverage shall be provided for:

1. Necessary care and treatment of medically diagnosed congenital defects and birth abnormalities, with coverage limits no more restrictive than for any injury or sickness covered under the insurance policy or subscription contract; and

2. Inpatient and outpatient dental, oral surgical, and orthodontic services which are medically necessary for the treatment of medically diagnosed cleft lip, cleft palate or ectodermal dysplasia. Such coverage shall be subject to any deductible, cost-sharing, and policy or contract maximum provisions, provided they are no more restrictive for such services than for any injury or sickness covered under the insurance policy or subscription contract.

C. If payment of a specific premium or subscription fee is required to provide coverage for a child, the policy or subscription contract may require that notification of birth of a newly born child and payment of the required premium or fees shall be furnished to the insurer issuing the policy or corporation issuing the subscription contract within thirty-one days after the date of birth in order to have the coverage continue beyond the thirty-one-day period.

§ 38.2-3411.1. Coverage for child health supervision services.

A. Every ~~individual or~~ group accident and sickness insurance policy, subscription contract providing coverage under a health services plan, or evidence of coverage of a health care plan delivered or issued

for delivery in the Commonwealth or renewed, reissued, or extended if already issued, shall offer and make available coverage under such policy or plan for child health supervision services to provide for the periodic examination of children covered under such policy or plan.

B. As used in this section, the term "child health supervision services" means the periodic review of a child's physical and emotional status by a licensed and qualified physician or pursuant to a physician's supervision. A review shall include but not be limited to a history, complete physical examination, developmental assessment, anticipatory guidance, appropriate immunizations, and laboratory tests in keeping with prevailing medical standards.

C. Each such policy or plan, offering and making available such coverage, shall, at a minimum, provide benefits for child health supervision services at approximately the following age intervals: birth, two months, four months, six months, nine months, twelve months, fifteen months, eighteen months, two years, three years, four years, five years, and six years. A policy or plan may provide that child health supervision services which are rendered during a periodic review shall only be covered to the extent that such services are provided by or under the supervision of a single physician during the course of one visit.

D. Benefits for coverage for child health supervision services shall be exempt from any copayment, coinsurance, deductible, or other dollar limit provision in the policy or plan. Such exemption shall be expressly stated on the policy, plan, rider, endorsement, or other attachment providing such coverage.

E. The premiums for such coverage shall take into consideration (i) the cost of providing such coverage, (ii) cost savings realized or likely to be realized as a consequence of such coverage, (iii) a reasonable profit for the insurer, and (iv) any other relevant information or data the Commission deems appropriate.

F. This section shall not apply (i) to any insurer or health services plan having fewer than 1,000 covered individuals insured or covered in Virginia or less than $500,000 in premiums in Virginia as of its last annual statement, (ii) to short-term travel or accident only policies, (iii) to short-term nonrenewable policies of not more than six months' duration, or (iv) to specified disease, hospital indemnity or other limited benefit policies issued to provide supplemental benefits to a policy providing primary care benefits.

§ 38.2-3411.2. Coverage of adopted children required.

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 that offers coverage for a family member of the insured, subscriber, or plan enrollee, shall, as to the family members' coverage, also provide that the accident and sickness insurance benefits applicable for children shall be payable with respect to adopted children of the insured, subscriber, or plan enrollee.

B. The coverage of such policy, subscription, or plan, applicable to family members of the insured, subscriber or enrollee, shall apply in the same manner and to the same but no greater extent to adopted children of the insured, subscriber or enrollee.

C. An adopted child shall be eligible for the coverage required by this section from the date of adoptive or parental placement with an insured, subscriber or plan enrollee for the purpose of adoption; and, in addition as to a child whose adoptive or parental placement has occurred within thirty-one days of birth, such child shall be considered a newborn child of the insured, subscriber or plan enrollee as of the date of adoptive or parental placement. Once coverage is in effect, it shall continue according to the terms of the policy, subscription contract, or plan, unless the said placement is disrupted prior to final decree of adoption, and the child is removed from placement with the insured, subscriber or plan enrollee.

D. If payment of a specific premium or subscription fee is required to provide coverage for a child, the policy or subscription contract may require notification of the placement of an adoptive child and payment of the required premium or fees shall be furnished to the insurer issuing the policy or corporation issuing the subscription contract within thirty-one days after the date of parental or adoptive placement in order to have the coverage continue beyond the thirty-one-day period.

E. No insurer, health services plan or health maintenance organization shall restrict coverage for any dependent child adopted or placed for adoption solely because of a preexisting condition of such child at the time that such child would otherwise become eligible for coverage under the plan.

§ 38.2-3411.3. Coverage for childhood immunizations.

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 all routine and necessary immunizations for newborn

children under such policy, contract or plan delivered, issued for delivery or renewed in this Commonwealth on and after July 1, 2000.

B. The required benefits shall apply to immunizations administered to each newborn child from birth to thirty-six months of age.

C. For the purpose of this section, "routine and necessary immunizations" means immunizations against diphtheria, pertussis, tetanus, polio, hepatitis B, measles, mumps, rubella, and other such immunizations as may be prescribed by the Commissioner of Health.

D. The provisions of this section shall not apply to any policy, contract or plan under which the policyholder has elected to obtain coverage for child health supervision services offered and made available under § 38.2-3411.1 or 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 federal governmental plans, or to short-term nonrenewable policies of not more than six months' duration.

§ 38.2-3411.4. Coverage for infant hearing screening and related diagnostics.

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 infant hearing screenings and all necessary audiological examinations provided pursuant to § 32.1-64.1 and as prescribed herein for newborn children under each such policy, contract or plan delivered, issued for delivery or renewed in this Commonwealth on and after July 1, 2001.

B. For purposes of this section, such coverage shall provide coverage for infant hearing screenings and all necessary audiological examinations provided pursuant to § 32.1-64.1 using any technology approved by the United States Food and Drug Administration, and as recommended by the national Joint Committee on Infant Hearing in its most current position statement addressing early hearing detection and intervention programs. Such coverage shall include benefits for any follow-up audiological examinations as recommended by a physician or audiologist and performed by a licensed audiologist to confirm the existence or absence of hearing loss.

C. Nothing contained in this section shall abrogate any obligation to provide coverage for hearing screening tests or any other hearing screening test or audiological diagnostic procedure pursuant to this section or any other law or regulation of the Commonwealth or of the United States or under the terms or provisions of any policy or plan issued, renewed, reissued or extended in the Commonwealth.

D. 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 federal governmental plans, or to short-term nonrenewable policies of not more than six months' duration.

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

A. As used in this section:

"Adult" means any person who is nineteen 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 State Mental Health, Mental Retardation and Substance Abuse Services Board 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 nineteen 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 twenty 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" 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" 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. 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 twenty 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 twenty-five days per policy or contract year.

3. Up to ten 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 which provides inpatient benefits in excess of twenty days per policy or contract year for adults or twenty-five 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. 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 twenty 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 fifty 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.

§ 38.2-3414.1. Obstetrical benefits; coverage for postpartum services.

A. Each insurer proposing to issue ~~an individual or~~ *a* group hospital policy or major medical policy in this Commonwealth, each corporation proposing to issue ~~an individual or~~ *a* group hospital, medical or major medical subscription contract, and each health maintenance organization providing a health care plan for health care services that provides benefits for obstetrical services shall provide coverage for postpartum services as provided in this section.

B. Such coverage shall include benefits for inpatient care and a home visit or visits which shall be in accordance with the medical criteria, outlined in the most current version of or an official update to the "Guidelines for Perinatal Care" prepared by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists or the "Standards for Obstetric-Gynecologic Services" prepared by the American College of Obstetricians and Gynecologists. Such coverage shall be provided incorporating any changes in such Guidelines or Standards within six months of the publication of such Guidelines or Standards or any official amendment thereto.

C. The requirements of this section shall apply to all insurance policies, contracts and plans delivered, issued for delivery, reissued, or extended on and after July 1, 1996, or at any time thereafter when any term of the policy, contract or plan is changed or any premium adjustment is made.

D. 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.

§ 38.2-3418. Coverage for victims of rape or incest.

Each hospital expense, medical-surgical expense, major medical expense or hospital confinement indemnity insurance policy issued by an insurer, each ~~individual and~~ group subscription contract providing hospital, medical, or surgical benefits issued by a corporation, and each contract issued by a health maintenance organization which provide benefits as a result of an "accident" or "accidental injury" shall be construed to include benefits for pregnancy following an act of rape of an insured or subscriber which was reported to the police within seven days following its occurrence, to the same extent as any other covered accident. The 7-day requirement shall be extended to 180 days in the case of an act of rape or incest of a female under 13 years of age.

§ 38.2-3418.1. Coverage for mammograms.

A. 1. 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 under such policy, contract or plan delivered, issued for delivery or renewed in this Commonwealth on and after July 1, 1996, for low-dose screening mammograms for determining the presence of occult breast cancer. Such coverage shall make available one screening mammogram to persons age thirty-five through thirty-nine, one such mammogram biennially to persons age forty through forty-nine, one such mammogram annually to persons age fifty and over and may be limited to a benefit of fifty dollars per mammogram subject to such dollar limits, deductibles and coinsurance factors as are no less favorable than for physical illness generally.

2. The term "mammogram" shall mean an X-ray examination of the breast using equipment dedicated specifically for mammography, including but not limited to the X-ray tube, filter, compression device, screens, film and cassettes, with an average radiation exposure of less than one rad mid-breast, two views of each breast.

B. In order to be considered a screening mammogram for which coverage shall be made available under this section:

1. The mammogram must be (i) ordered by a health care practitioner acting within the scope of his licensure and, in the case of an enrollee of a health maintenance organization, by the health maintenance organization physician, (ii) performed by a registered technologist, (iii) interpreted by a qualified radiologist, (iv) performed under the direction of a person licensed to practice medicine and surgery and certified by the American Board of Radiology or an equivalent examining body and (v) a copy of the mammogram report must be sent or delivered to the health care practitioner who ordered it;

2. The equipment used to perform the mammogram shall meet the standards set forth by the Virginia Department of Health in its radiation protection regulations; and

3. The mammography film shall be retained by the radiologic facility performing the examination in accordance with the American College of Radiology guidelines or state law.

C. The provisions of this section shall not apply to short-term travel, accident only, limited or specified disease policies, or to short-term nonrenewable policies of not more than six months' duration.

§ 38.2-3418.1:2. Coverage for pap smears.

A. Notwithstanding the provisions § 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 under such policy, contract or plan delivered, issued for delivery or renewed in this Commonwealth on and after July 1, 1996, for annual pap smears, including coverage, on and after July 1, 1999, for annual testing performed by any FDA-approved gynecologic cytology screening technologies.

B. The provisions of this section shall not apply to short-term travel, accident only, limited or specified disease policies, or to short-term nonrenewable policies of not more than six months' duration.

§ 38.2-3418.2. Coverage of procedures involving bones and joints.

A. 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 that provides coverage under such policy, contract or plan for diagnostic and surgical treatment involving any bone or joint of the skeletal structure shall not, under such policy, contract or plan delivered, issued for delivery or renewed in this Commonwealth on and after July 1, 1995, exclude coverage for such diagnostic and surgical treatment involving any bone or joint of the head, neck, face or jaw or impose limits that are more restrictive than limits on coverage applicable to such treatment involving any bone or joint of the skeletal structure if the treatment is required because of a medical condition or injury which prevents normal function of the joint or bone and is deemed medically necessary to attain functional capacity of the affected part.

B. The provisions of this section shall not apply to short-term travel, accident-only, limited or specified disease policies, or to short-term nonrenewable policies of not more than six months' duration.

§ 38.2-3418.3. Coverage for hemophilia and congenital bleeding disorders.

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 hemophilia and congenital bleeding disorders under such policy, contract or plan delivered, issued for delivery or renewed in this Commonwealth on and after July 1, 1998.

B. For the purpose of this section:

"Blood infusion equipment" includes, but is not limited to, syringes and needles.

"Blood product" includes, but is not limited to, Factor VII, Factor VIII, Factor IX, and cryoprecipitate.

"Hemophilia" means a lifelong hereditary bleeding disorder usually affecting males that results in prolonged bleeding primarily into joints and muscles.

"Home treatment program" means a program where individuals or family members are trained to provide infusion therapy at home in order to achieve optimal health and cost effectiveness.

"State-approved hemophilia treatment center" means a hospital or clinic which receives federal or state Maternal and Child Health Bureau, and/or Centers for Disease Control funds to conduct comprehensive care for persons with hemophilia and other congenital bleeding disorders.

C. The benefits to be provided shall include coverage for expenses incurred in connection with the treatment of routine bleeding episodes associated with hemophilia and other congenital bleeding disorders. The benefits to be provided shall include coverage for the purchase of blood products and blood infusion equipment required for home treatment of routine bleeding episodes associated with hemophilia and other congenital bleeding disorders when the home treatment program is under the

supervision of the state-approved hemophilia treatment center.

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

§ 38.2-3418.4. Coverage for reconstructive breast surgery; notice; eligibility.

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 reconstructive breast surgery under such policy, contract or plan delivered, issued for delivery or renewed in this Commonwealth.

B. The reimbursement for reconstructive breast surgery shall be determined according to the same formula by which charges are developed for other medical and surgical procedures. Such coverage shall have durational limits, dollar limits, deductibles and coinsurance factors that are no less favorable than for physical illness generally. Coverage shall be provided in a manner determined in consultation with the attending physician and the patient.

C. For purposes of this section, "mastectomy" means the surgical removal of all or part of the breast and "reconstructive breast surgery" means surgery performed (i) coincident with or following a mastectomy or (ii) following a mastectomy to reestablish symmetry between the two breasts, for reconstructive breast surgery performed on or after October 21, 1998, and while the patient is or was a covered person under the policy, contract or plan. Reconstructive breast surgery shall also include coverage for prostheses, determined as necessary in consultation with the attending physician and patient, and physical complications of mastectomy, including medically necessary treatment of lymphedemas.

D. Written notice of the availability of this coverage shall be provided to the subscribers upon enrollment in the policy and annually thereafter. Such notice shall be prominently positioned in any literature or correspondence provided to the subscribers.

E. Eligibility for coverage shall not be denied solely for the purpose of avoiding the requirements of this section, nor shall an attending provider be penalized or have the reimbursement reduced or incentives, monetary or otherwise, provided to induce such provider to provide care in a manner inconsistent with this section.

F. The provisions of this section shall not apply to short-term travel, accident only, limited or specified disease policies (except policies issued for cancer), 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 or to short-term nonrenewable policies of not more than six months' duration.

§ 38.2-3418.5. Coverage for early intervention services.

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 medically necessary early intervention services under such policy, contract or plan delivered, issued for delivery or renewed in this Commonwealth on and after July 1, 1998. Such coverage shall be limited to a benefit of $5,000 per insured or member per policy or calendar year and, except as set forth in subsection C, shall be subject to such dollar limits, deductibles and coinsurance factors as are no less favorable than for physical illness generally.

B. For the purpose of this section, "early intervention services" means medically necessary speech and language therapy, occupational therapy, physical therapy and assistive technology services and devices for dependents from birth to age three who are certified by the Department of Mental Health, Mental Retardation and Substance Abuse Services as eligible for services under Part H of the Individuals with Disabilities Education Act (20 U.S.C. § 1471 et seq.). "Medically necessary early intervention services for the population certified by the Department of Mental Health, Mental Retardation and Substance Abuse Services" shall mean those services designed to help an individual attain or retain the capability to function age-appropriately within his environment, and shall include services that enhance functional ability without effecting a cure.

C. The cost of early intervention services shall not be applied to any contractual provision limiting the total amount of coverage paid by the insurer, corporation or health maintenance organization to or on behalf of the insured or member during the insured's or member's lifetime.

D. "Financial costs," as used in this section, shall mean any copayment, coinsurance, or deductible in

the policy or plan. Financial costs may be paid through the use of federal Part H program funds, state general funds, or local government funds appropriated to implement Part H services for families who may refuse the use of their insurance to pay for early intervention services due to a financial cost.

E. The provisions of this section shall not apply to short-term travel, accident only, limited or specified disease policies, 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.

§ 38.2-3418.6. Minimum hospital stay for mastectomy and certain lymph node dissection patients.

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 providing a minimum stay in the hospital of not less than forty-eight hours for a patient following a radical or modified radical mastectomy and not less than twenty-four hours of inpatient care following a total mastectomy or a partial mastectomy with lymph node dissection for the treatment of breast cancer. Nothing in this section shall be construed as requiring the provision of inpatient coverage where the attending physician in consultation with the patient determines that a shorter period of hospital stay is appropriate. Such provision shall be included under any policy, contract or plan delivered, issued for delivery or renewed in this Commonwealth on and after July 1, 1998.

The provisions of this section shall not apply to short-term travel, accident only, limited or specified disease policies, 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, or to short-term nonrenewable policies of not more than six months' duration.

§ 38.2-3418.7. Coverage for PSA testing.

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 to (i) persons age fifty and over and (ii) persons age forty and over who are at high risk for prostate cancer, according to the most recent published guidelines of the American Cancer Society, for one PSA test in a twelve-month period and digital rectal examinations, all in accordance with American Cancer Society guidelines under any such policy, contract or plan delivered, issued for delivery or renewed in this Commonwealth on and after July 1, 1998.

B. For the purpose of this section, "PSA testing" means the analysis of a blood sample to determine the level of prostate specific antigen.

C. The provisions of this section shall not apply to (i) short-term travel, accident only, limited or specified disease policies other than cancer policies, (ii) short-term nonrenewable policies of not more than six months' duration, or (iii) 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.

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

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 colorectal cancer screening under any such policy, contract or plan delivered, issued for delivery or renewed in this Commonwealth, on and after July 1, 2000.

B. Coverage for colorectal cancer screening, specifically screening with an annual fecal occult blood test, flexible sigmoidoscopy or colonoscopy, or in appropriate circumstances radiologic imaging, shall be provided in accordance with the most recently published recommendations established by the American College of Gastroenterology, in consultation with the American Cancer Society, for the ages, family histories, and frequencies referenced in such recommendations.

C. The coverage provided under this section shall not be more restrictive than or separate from coverage provided 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 copayments and coinsurance factors.

D. The provisions of this section shall not apply to (i) short-term travel, accident only, limited or specified disease policies, other than cancer policies, (ii) short-term nonrenewable policies of not more than six months duration, or (iii) 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.

§ 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.

§ 38.2-3418.9. Minimum hospital stay for hysterectomy.

A. Notwithstanding the provisions of § 38.2-3419, each insurer proposing to issue ~~an individual or~~ *a* group hospital policy or major medical policy in this Commonwealth, each corporation proposing to issue ~~an individual or~~ *a* group hospital, medical or major medical subscription contract, and each health maintenance organization providing a health care plan for health care shall provide coverage for laparoscopy-assisted vaginal hysterectomy and vaginal hysterectomy as provided in this section.

B. Such coverage shall include benefits for a minimum stay in the hospital of not less than twenty-three hours for a laparoscopy-assisted vaginal hysterectomy and forty-eight hours for a vaginal hysterectomy. Nothing in this subsection shall be construed as requiring the provision of the total hours referenced when the attending physician, in consultation with the patient, determines that a shorter period of hospital stay is appropriate.

C. The requirements of this section shall apply to all insurance policies, contracts and plans delivered, issued for delivery, reissued, or extended on and after July 1, 1999, or at any time thereafter when any term of the policy, contract or plan is changed or any premium adjustment is made.

D. 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.

§ 38.2-3418.10. Coverage for diabetes.

A. Each insurer proposing to issue ~~an individual or~~ *a* group hospital policy or major medical policy in this Commonwealth, each corporation proposing to issue ~~an individual or~~ *a* group hospital, medical or major medical subscription contract, and each health maintenance organization providing a health care plan for health care services shall provide coverage for diabetes as provided in this section.

B. Such coverage shall include benefits for equipment, supplies and in-person outpatient self-management training and education, including medical nutrition therapy, for the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes and noninsulin-using diabetes if prescribed by a health care professional legally authorized to prescribe such items under law. As used herein, the terms "equipment" and "supplies" shall not be considered durable medical equipment.

C. To qualify for coverage under this section, diabetes in-person outpatient self-management training and education shall be provided by a certified, registered or licensed health care professional. A managed care health insurance plan, as defined in Chapter 58 (§ 38.2-5800 et seq.) of this title, may require such health care professional to be a member of the plan's provider network; provided that such network includes sufficient health care professionals who are qualified by specific education, experience, and credentials to provide the covered benefits described in this section.

D. No insurer, corporation, or health maintenance organization shall impose upon any person receiving benefits pursuant to this section any copayment, fee or condition that is not equally imposed upon all individuals in the same benefit category, nor shall any insurer, corporation or health maintenance organization impose any policy-year or calendar-year dollar or durational benefit limitations or maximums for benefits or services provided under this section.

E. The requirements of this section shall apply to all insurance policies, contracts and plans delivered, issued for delivery, reissued, or extended on and after July 1, 2000, or at any time thereafter when any term of the policy, contract or plan is changed or any premium adjustment is made.

F. 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.

§ 38.2-3418.11. Coverage for hospice care.

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 hospice services under such policy, contract or plan delivered, issued for delivery or renewed in this Commonwealth on and after July 1, 1999.

B. As used in this section:

"Hospice services" shall mean a coordinated program of home and inpatient care provided directly or under the direction of a hospice licensed under Article 7 (§ 32.1-162.1 et seq.) of Chapter 5 of Title 32.1, and shall include palliative and supportive physical, psychological, psychosocial and other health services to individuals with a terminal illness utilizing a medically directed interdisciplinary team.

"Individuals with a terminal illness" shall mean individuals whose condition has been diagnosed as terminal by a licensed physician, whose medical prognosis is death within six months, and who elect to receive palliative rather than curative care.

"Medicare" shall mean Title XVIII of the Social Security Act.

"Palliative care" shall mean treatment directed at controlling pain, relieving other symptoms, and focusing on the special needs of the patient as he experiences the stress of the dying process, rather than treatment aimed at investigation and intervention for the purpose of cure or prolongation of life.

C. For the purposes of this section, documentation requirements shall be no greater than those required for the same services under Medicare.

D. Nothing in this section shall prohibit an insurer, corporation, or health maintenance organization from offering or providing coverage for hospice services when it cannot be demonstrated that the illness is terminal or for individuals with life expectancies of longer than six months.

E. The provisions of this section shall not apply to short-term travel, accident only, short-term nonrenewable policies of not more than six months' duration, or 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.

§ 38.2-3418.12. Coverage for hospitalization and anesthesia for dental procedures.

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 medically necessary general anesthesia and hospitalization or facility charges of a facility licensed to provide outpatient surgical procedures for dental care provided to a covered person who is determined by a licensed dentist in consultation with the covered person's treating physician to require general anesthesia and admission to a hospital or outpatient surgery facility to effectively and safely provide dental care and (i) is under the age of five, or (ii) is severely disabled, or (iii) has a medical condition and requires admission to a hospital or outpatient surgery facility and general anesthesia for dental care treatment. For purposes of this section, a determination of medical necessity shall include but not be limited to a consideration of whether the age, physical condition or mental condition of the covered person requires the utilization of general anesthesia and the admission to a hospital or outpatient surgery facility to safely provide the underlying dental care.

B. Such insurer, corporation or health maintenance organization may require prior authorization for general anesthesia and hospitalization or surgical facility charges for dental procedures in the same manner that prior authorization is required for other covered benefits.

C. Such insurer, corporation or health maintenance organization shall restrict coverage for general anesthesia expenses to those health care providers who are licensed to provide anesthesia services and shall restrict coverage for facility charges to facilities licensed to provide surgical services.

D. The provisions of this section shall not be construed to require coverage for dental care incident to the coverage provided in this section.

E. The provisions of this section are applicable to any policy, contract or plan delivered, issued for delivery or renewed in this Commonwealth on and after July 1, 2000.

F. The provisions of this section shall not apply to short-term travel, accident-only, limited or specified disease policies, 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.

§ 38.2-3418.13. Coverage for the treatment of morbid obesity.

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 offer and make available coverage under any such policy, contract or plan for the treatment of morbid obesity through gastric bypass surgery or such other methods as may be recognized by the National Institutes of Health as effective for the long-term reversal of morbid obesity. The provisions of this section shall apply to any such policy, contract or plan delivered, issued for delivery, or renewed in this Commonwealth on and after July 1, 2000.

B. The reimbursement for the treatment of morbid obesity shall be determined according to the same formula by which charges are developed 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. Standards and criteria, including those related to diet, used by insurers to approve or restrict access to surgery for morbid obesity shall be based upon current clinical guidelines recognized by the National Institutes of Health.

C. For purposes of this section, "morbid obesity" means (i) a weight that is at least 100 pounds over or twice the ideal weight for frame, age, height, and gender as specified in the 1983 Metropolitan Life Insurance tables, (ii) a body mass index (BMI) equal to or greater than 35 kilograms per meter squared

with comorbidity or coexisting medical conditions such as hypertension, cardiopulmonary conditions, sleep apnea, or diabetes, or (iii) a BMI of 40 kilograms per meter squared without such comorbidity. As used herein, BMI equals weight in kilograms divided by height in meters squared.

D. 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.

§ 38.2-3418.14. Coverage for lymphedema.

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 lymphedema as provided in this section.

B. Coverage under this section shall include benefits for equipment, supplies, complex decongestive therapy, and outpatient self-management training and education for the treatment of lymphedema, if prescribed by a health care professional legally authorized to prescribe or provide such items under law.

C. A managed care health insurance plan, as defined in Chapter 58 (§ 38.2-5800 et seq.) of this title, may require such health care professional to be a member of the plan's provider network, provided that such network includes sufficient health care professionals who are qualified by specific education, experience, and credentials to provide the covered benefits described in this section.

D. No insurer, corporation, or health maintenance organization shall impose upon any person receiving benefits pursuant to this section any copayment, fee, policy year or calendar year, or durational benefit limitation or maximum for benefits or services that is not equally imposed upon all individuals in the same benefit category.

E. The requirements of this section shall apply to all insurance policies, contracts and plans delivered, issued for delivery, reissued, or extended in this Commonwealth on and after January 1, 2004, or at any time thereafter when any term of the policy, contract or plan is changed or any premium adjustment is made.

F. 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.