22101287D

HOUSE BILL NO. 512

Offered January 12, 2022

Prefiled January 11, 2022

A BILL to amend and reenact §§ 2.2-2901.1, 2.2-3004, 15.2-1500.1, 15.2-1507, 15.2-1604, 22.1-271.2, 22.1-271.4, 22.1-289.031, 22.1-295.2, 22.1-306, 23.1-800, 32.1-43, 32.1-47, 32.1-47.1, 32.1-48, 32.1-127, 38.2-3407.15, 38.2-3438, 38.2-3454, 44-146.17, as it is currently effective and as it shall become effective, 63.2-603, and 65.2-402.1 of the Code of Virginia and to amend the Code of Virginia by adding in Article 2 of Chapter 1 of Title 32.1 a section numbered 32.1-15.2, by adding in Article 3 of Chapter 2 of Title 32.1 a section numbered 32.1-48.002, by adding in Chapter 2 of Title 37.2 a section numbered 37.2-205, by adding sections numbered 38.2-3100.4 and 40.1-27.5, by adding in Article 4 of Chapter 3 of Title 46.2 a section numbered 46.2-333.2, by adding in Chapter 24 of Title 54.1 a section numbered 54.1-2409.6, and by adding in Article 2 of Chapter 2 of Title 63.2 a section numbered 63.2-221.1, relating to COVID-19 vaccination status; discrimination prohibited.

Patrons—March, LaRock and Williams

Referred to Committee on Health, Welfare and Institutions

Be it enacted by the General Assembly of Virginia:

1. That §§ 2.2-2901.1, 2.2-3004, 15.2-1500.1, 15.2-1507, 15.2-1604, 22.1-271.2, 22.1-271.4, 22.1-289.031, 22.1-295.2, 22.1-306, 23.1-800, 32.1-43, 32.1-47, 32.1-47.1, 32.1-48, 32.1-127, 38.2-3407.15, 38.2-3438, 38.2-3454, 44-146.17, as it is currently effective and as it shall become effective, 63.2-603, and 65.2-402.1 of the Code of Virginia are amended and reenacted and that the Code of Virginia is amended by adding in Article 2 of Chapter 1 of Title 32.1 a section numbered 32.1-15.2, by adding in Article 3 of Chapter 2 of Title 32.1 a section numbered 32.1-48.002, by adding in Chapter 2 of Title 37.2 a section numbered 37.2-205, by adding sections numbered 38.2-3100.4 and 40.1-27.5, by adding in Article 4 of Chapter 3 of Title 46.2 a section numbered 46.2-333.2, by adding in Chapter 24 of Title 54.1 a section numbered 54.1-2409.6, and by adding in Article 2 of Chapter 2 of Title 63.2 a section numbered 63.2-221.1 as follows:

§ 2.2-2901.1. Employment discrimination prohibited.

A. As used in this section:

"Age" means being an individual who is at least 40 years of age.

"Military status" means status as (i) a member of the uniformed forces, as defined in 10 U.S.C. § 101(a)(5), of the United States or a reserve component thereof named under 10 U.S.C. § 10101, (ii) a veteran as defined in 38 U.S.C. § 101(2), or (iii) a dependent as defined in 50 U.S.C. § 3911(4) except that the support provided by the service member to the individual shall have been provided 180 days immediately preceding an alleged action that if proven true would constitute unlawful discrimination under this section instead of 180 days immediately preceding an application for relief under 50 U.S.C. Chapter 50.

B. No state agency, institution, board, bureau, commission, council, or instrumentality of the Commonwealth shall discriminate in employment on the basis of race, color, religion, national origin, sex, pregnancy, childbirth or related medical conditions, age, marital status, disability, sexual orientation, gender identity, ~~or~~ military status, *or COVID-19 vaccination status*.

C. The provisions of this section shall not prohibit (i) discrimination in employment on the basis of (a) sex or age in those instances when sex or age is a bona fide occupational qualification for employment or (b) disability when using the alternative application process provided for in § 2.2-1213 or (ii) providing preference in employment to veterans.

§ 2.2-3004. Grievances qualifying for a grievance hearing; grievance hearing generally.

A. A grievance qualifying for a hearing shall involve a complaint or dispute by an employee relating to the following adverse employment actions in which the employee is personally involved, including (i) formal disciplinary actions, including suspensions, demotions, transfers and assignments, and dismissals resulting from formal discipline or unsatisfactory job performance; (ii) the application of all written personnel policies, procedures, rules and regulations where it can be shown that policy was misapplied or unfairly applied; (iii) discrimination on the basis of race, color, religion, political affiliation, age, disability, national origin, sex, pregnancy, childbirth or related medical conditions, marital status, sexual orientation, gender identity, ~~or~~ military status, *or COVID-19 vaccination status*; (iv) arbitrary or capricious performance evaluations; (v) acts of retaliation as the result of the use of or participation in the grievance procedure or because the employee has complied with any law of the United States or of

the Commonwealth, has reported any violation of such law to a governmental authority, has sought any change in law before the Congress of the United States or the General Assembly, or has reported an incidence of fraud, abuse, or gross mismanagement; and (vi) retaliation for exercising any right otherwise protected by law.

B. Management reserves the exclusive right to manage the affairs and operations of state government. Management shall exercise its powers with the highest degree of trust. In any employment matter that management precludes from proceeding to a grievance hearing, management's response, including any appropriate remedial actions, shall be prompt, complete, and fair.

C. Complaints relating solely to the following issues shall not proceed to a hearing: (i) establishment and revision of wages, salaries, position classifications, or general benefits; (ii) work activity accepted by the employee as a condition of employment or which may reasonably be expected to be a part of the job content; (iii) contents of ordinances, statutes or established personnel policies, procedures, and rules and regulations; (iv) methods, means, and personnel by which work activities are to be carried on; (v) termination, layoff, demotion, or suspension from duties because of lack of work, reduction in work force, or job abolition; (vi) hiring, promotion, transfer, assignment, and retention of employees within the agency; and (vii) relief of employees from duties of the agency in emergencies.

D. Except as provided in subsection A of § 2.2-3003, decisions regarding whether a grievance qualifies for a hearing shall be made in writing by the agency head or his designee within five workdays of the employee's request for a hearing. A copy of the decision shall be sent to the employee. The employee may appeal the denial of a hearing by the agency head to the Director of the Department of Human Resource Management (the Director). Upon receipt of an appeal, the agency shall transmit the entire grievance record to the Department of Human Resource Management within five workdays. The Director shall render a decision on whether the employee is entitled to a hearing upon the grievance record and other probative evidence.

E. The hearing pursuant to § 2.2-3005 shall be held in the locality in which the employee is employed or in any other locality agreed to by the employee, employer, and hearing officer. The employee and the agency may be represented by legal counsel or a lay advocate, the provisions of § 54.1-3904 notwithstanding. The employee and the agency may call witnesses to present testimony and be cross-examined.

§ 15.2-1500.1. Employment discrimination prohibited.

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

"Age" means being an individual who is at least 40 years of age.

"Military status" means status as (i) a member of the uniformed forces, as defined in 10 U.S.C. § 101(a)(5), of the United States or a reserve component thereof named under 10 U.S.C. § 10101, (ii) a veteran as defined in 38 U.S.C. § 101(2), or (iii) a dependent as defined in 50 U.S.C. § 3911(4) except that the support provided by the service member to the individual shall have been provided 180 days immediately preceding an alleged action that if proven true would constitute unlawful discrimination under this section instead of 180 days immediately preceding an application for relief under 50 U.S.C. Chapter 50.

B. No department, office, board, commission, agency, or instrumentality of local government shall discriminate in employment on the basis of race, color, religion, national origin, sex, pregnancy, childbirth or related medical conditions, age, marital status, disability, sexual orientation, gender identity, ~~or~~ military status, *or COVID-19 vaccination status*.

C. The provisions of this section shall not prohibit (i) discrimination in employment on the basis of sex or age in those instances when sex or age is a bona fide occupational qualification for employment or (ii) providing preference in employment to veterans.

§ 15.2-1507. Provision of grievance procedure; training programs.

A. If a local governing body fails to adopt a grievance procedure required by § 15.2-1506 or fails to certify it as provided in this section, the local governing body shall be deemed to have adopted a grievance procedure that is consistent with the provisions of Chapter 30 (§ 2.2-3000 et seq.) of Title 2.2 and any regulations adopted pursuant thereto for so long as the locality remains in noncompliance. The locality shall provide its employees with copies of the applicable grievance procedure upon request. The term "grievance" as used herein shall not be interpreted to mean negotiations of wages, salaries, or fringe benefits.

Each grievance procedure, and each amendment thereto, in order to comply with this section, shall be certified in writing to be in compliance by the city, town, or county attorney, and the chief administrative officer of the locality, and such certification filed with the clerk of the circuit court having jurisdiction in the locality in which the procedure is to apply. Local government grievance procedures in effect as of July 1, 1991, shall remain in full force and effect for 90 days thereafter, unless certified and filed as provided above within a shorter time period.

Each grievance procedure shall include the following components and features:

1. Definition of grievance. A grievance shall be a complaint or dispute by an employee relating to

his employment, including (i) disciplinary actions, including dismissals, disciplinary demotions, and suspensions, provided that dismissals shall be grievable whenever resulting from formal discipline or unsatisfactory job performance; (ii) the application of personnel policies, procedures, rules, and regulations, including the application of policies involving matters referred to in clause (iii) of subdivision 2; (iii) discrimination on the basis of race, color, creed, religion, political affiliation, age, disability, national origin, sex, marital status, pregnancy, childbirth or related medical conditions, sexual orientation, gender identity, ~~or~~ military status, *or COVID-19 vaccination status*; and (iv) acts of retaliation as the result of the use of or participation in the grievance procedure or because the employee has complied with any law of the United States or of the Commonwealth, has reported any violation of such law to a governmental authority, has sought any change in law before the Congress of the United States or the General Assembly, or has reported an incidence of fraud, abuse, or gross mismanagement. For the purposes of clause (iv), there shall be a rebuttable presumption that increasing the penalty that is the subject of the grievance at any level of the grievance shall be an act of retaliation.

2. Local government responsibilities. Local governments shall retain the exclusive right to manage the affairs and operations of government. Accordingly, the following complaints are nongrievable: (i) establishment and revision of wages or salaries, position classification, or general benefits; (ii) work activity accepted by the employee as a condition of employment or work activity that may reasonably be expected to be a part of the job content; (iii) the contents of ordinances, statutes, or established personnel policies, procedures, rules, and regulations; (iv) failure to promote except where the employee can show that established promotional policies or procedures were not followed or applied fairly; (v) the methods, means, and personnel by which work activities are to be carried on; (vi) except where such action affects an employee who has been reinstated within the previous six months as the result of the final determination of a grievance, termination, layoff, demotion, or suspension from duties because of lack of work, reduction in work force, or job abolition; (vii) the hiring, promotion, transfer, assignment, and retention of employees within the local government; and (viii) the relief of employees from duties of the local government in emergencies. In any grievance brought under the exception to clause (vi), the action shall be upheld upon a showing by the local government that (a) there was a valid business reason for the action and (b) the employee was notified of the reason in writing prior to the effective date of the action.

3. Coverage of personnel.

a. Unless otherwise provided by law, all nonprobationary local government permanent full-time and part-time employees are eligible to file grievances with the following exceptions:

(1) Appointees of elected groups or individuals;

(2) Officials and employees who by charter or other law serve at the will or pleasure of an appointing authority;

(3) Deputies and executive assistants to the chief administrative officer of a locality;

(4) Agency heads or chief executive officers of government operations;

(5) Employees whose terms of employment are limited by law;

(6) Temporary, limited term, and seasonal employees;

(7) Law-enforcement officers as defined in Chapter 5 (§ 9.1-500 et seq.) of Title 9.1 whose grievance is subject to the provisions of Chapter 5 (§ 9.1-500 et seq.) of Title 9.1 and who have elected to proceed pursuant to those provisions in the resolution of their grievance, or any other employee electing to proceed pursuant to any other existing procedure in the resolution of his grievance; and

(8) Law-enforcement officers as defined in § 9.1-601 whose grievance is subject to the provisions of § 9.1-601 and relates to a binding disciplinary determination made by a law-enforcement civilian oversight body, except as permitted by subsection F of § 9.1-601.

b. Notwithstanding the exceptions set forth in subdivision a, local governments, at their sole discretion, may voluntarily include employees in any of the excepted categories within the coverage of their grievance procedures.

c. The chief administrative officer of each local government, or his designee, shall determine the officers and employees excluded from the grievance procedure, and shall be responsible for maintaining an up-to-date list of the affected positions.

4. Grievance procedure availability and coverage for employees of community services boards, redevelopment and housing authorities, and regional housing authorities. Employees of community services boards, redevelopment and housing authorities created pursuant to § 36-4, and regional housing authorities created pursuant to § 36-40 shall be included in (i) a local governing body's grievance procedure or personnel system, if agreed to by the department, board, or authority and the locality or (ii) a grievance procedure established and administered by the department, board, or authority that is consistent with the provisions of Chapter 30 (§ 2.2-3000 et seq.) of Title 2.2 and any regulations promulgated pursuant thereto. If a department, board, or authority fails to establish a grievance procedure pursuant to clause (i) or (ii), it shall be deemed to have adopted a grievance procedure that is

consistent with the provisions of Chapter 30 (§ 2.2-3000 et seq.) of Title 2.2 and any regulations adopted pursuant thereto for so long as it remains in noncompliance.

5. General requirements for procedures.

a. Each grievance procedure shall include not more than four steps for airing complaints at successively higher levels of local government management, and a final step providing for a panel hearing or a hearing before an administrative hearing officer upon the agreement of both parties.

b. Grievance procedures shall prescribe reasonable and specific time limitations for the grievant to submit an initial complaint and to appeal each decision through the steps of the grievance procedure.

c. Nothing contained in this section shall prohibit a local government from granting its employees rights greater than those contained herein, provided that such grant does not exceed or violate the general law or public policy of the Commonwealth.

6. Time periods.

a. It is intended that speedy attention to employee grievances be promoted, consistent with the ability of the parties to prepare for a fair consideration of the issues of concern.

b. The time for submitting an initial complaint shall not be less than 20 calendar days after the event giving rise to the grievance, but local governments may, at their option, allow a longer time period.

c. Limits for steps after initial presentation of grievance shall be the same or greater for the grievant than the time that is allowed for local government response in each comparable situation.

d. Time frames may be extended by mutual agreement of the local government and the grievant.

7. Compliance.

a. After the initial filing of a written grievance, failure of either party to comply with all substantial procedural requirements of the grievance procedure, including the panel or administrative hearing, without just cause shall result in a decision in favor of the other party on any grievable issue, provided the party not in compliance fails to correct the noncompliance within five workdays of receipt of written notification by the other party of the compliance violation. Such written notification by the grievant shall be made to the chief administrative officer, or his designee.

b. The chief administrative officer, or his designee, at his option, may require a clear written explanation of the basis for just cause extensions or exceptions. The chief administrative officer, or his designee, shall determine compliance issues. Compliance determinations made by the chief administrative officer shall be subject to judicial review by filing petition with the circuit court within 30 days of the compliance determination.

8. Management steps.

a. The first step shall provide for an informal, initial processing of employee complaints by the immediate supervisor through a nonwritten, discussion format.

b. Management steps shall provide for a review with higher levels of local government authority following the employee's reduction to writing of the grievance and the relief requested on forms supplied by the local government. Personal face-to-face meetings are required at all of these steps.

c. With the exception of the final management step, the only persons who may normally be present in the management step meetings are the grievant, the appropriate local government official at the level at which the grievance is being heard, and appropriate witnesses for each side. Witnesses shall be present only while actually providing testimony. At the final management step, the grievant, at his option, may have present a representative of his choice. If the grievant is represented by legal counsel, local government likewise has the option of being represented by counsel.

9. Qualification for panel or administrative hearing.

a. Decisions regarding grievability and access to the procedure shall be made by the chief administrative officer of the local government, or his designee, at any time prior to the panel hearing, at the request of the local government or grievant, within 10 calendar days of the request. No city, town, or county attorney, or attorney for the Commonwealth, shall be authorized to decide the question of grievability. A copy of the ruling shall be sent to the grievant. Decisions of the chief administrative officer of the local government, or his designee, may be appealed to the circuit court having jurisdiction in the locality in which the grievant is employed for a hearing on the issue of whether the grievance qualifies for a panel hearing. Proceedings for review of the decision of the chief administrative officer or his designee shall be instituted by the grievant by filing a notice of appeal with the chief administrative officer within 10 calendar days from the date of receipt of the decision and giving a copy thereof to all other parties. Within 10 calendar days thereafter, the chief administrative officer or his designee shall transmit to the clerk of the court to which the appeal is taken: a copy of the decision of the chief administrative officer, a copy of the notice of appeal, and the exhibits. A list of the evidence furnished to the court shall also be furnished to the grievant. The failure of the chief administrative officer or his designee to transmit the record shall not prejudice the rights of the grievant. The court, on motion of the grievant, may issue a writ of certiorari requiring the chief administrative officer to transmit the record on or before a certain date.

b. Within 30 days of receipt of such records by the clerk, the court, sitting without a jury, shall hear

the appeal on the record transmitted by the chief administrative officer or his designee and such additional evidence as may be necessary to resolve any controversy as to the correctness of the record. The court, in its discretion, may receive such other evidence as the ends of justice require. The court may affirm the decision of the chief administrative officer or his designee, or may reverse or modify the decision. The decision of the court shall be rendered no later than the fifteenth day from the date of the conclusion of the hearing. The decision of the court is final and is not appealable.

10. Final hearings.

a. Qualifying grievances shall advance to either a panel hearing or a hearing before an administrative hearing officer, as set forth in the locality's grievance procedure, as described below:

(1) If the grievance procedure adopted by the local governing body provides that the final step shall be an impartial panel hearing, the panel may, with the exception of those local governments covered by subdivision a (2), consist of one member appointed by the grievant, one member appointed by the agency head and a third member selected by the first two. In the event that agreement cannot be reached as to the final panel member, the chief judge of the circuit court of the jurisdiction wherein the dispute arose shall select the third panel member. The panel shall not be composed of any persons having direct involvement with the grievance being heard by the panel, or with the complaint or dispute giving rise to the grievance. Managers who are in a direct line of supervision of a grievant, persons residing in the same household as the grievant and the following relatives of a participant in the grievance process or a participant's spouse are prohibited from serving as panel members: spouse, parent, child, descendants of a child, sibling, niece, nephew and first cousin. No attorney having direct involvement with the subject matter of the grievance, nor a partner, associate, employee or co-employee of the attorney shall serve as a panel member.

(2) If the grievance procedure adopted by the local governing body provides for the final step to be an impartial panel hearing, local governments may retain the panel composition method previously approved by the Department of Human Resource Management and in effect as of the enactment of this statute. Modifications to the panel composition method shall be permitted with regard to the size of the panel and the terms of office for panel members, so long as the basic integrity and independence of panels are maintained. As used in this section, the term "panel" shall include all bodies designated and authorized to make final and binding decisions.

(3) When a local government elects to use an administrative hearing officer rather than a three-person panel for the final step in the grievance procedure, the administrative hearing officer shall be appointed by the Executive Secretary of the Supreme Court of Virginia. The appointment shall be made from the list of administrative hearing officers maintained by the Executive Secretary pursuant to § 2.2-4024 and shall be made from the appropriate geographical region on a rotating basis. In the alternative, the local government may request the appointment of an administrative hearing officer from the Department of Human Resource Management. If a local government elects to use an administrative hearing officer, it shall bear the expense of such officer's services.

(4) When the local government uses a panel in the final step of the procedure, there shall be a chairperson of the panel and, when panels are composed of three persons (one each selected by the respective parties and the third from an impartial source), the third member shall be the chairperson.

(5) Both the grievant and the respondent may call upon appropriate witnesses and be represented by legal counsel or other representatives at the hearing. Such representatives may examine, cross-examine, question and present evidence on behalf of the grievant or respondent before the panel or hearing officer without being in violation of the provisions of § 54.1-3904.

(6) The decision of the panel or hearing officer shall be final and binding and shall be consistent with provisions of law and written policy.

(7) The question of whether the relief granted by a panel or hearing officer is consistent with written policy shall be determined by the chief administrative officer of the local government, or his designee, unless such person has a direct personal involvement with the event or events giving rise to the grievance, in which case the decision shall be made by the attorney for the Commonwealth of the jurisdiction in which the grievance is pending.

b. Rules for panel and administrative hearings.

Unless otherwise provided by law, local governments shall adopt rules for the conduct of panel or administrative hearings as a part of their grievance procedures, or shall adopt separate rules for such hearings. Rules that are promulgated shall include the following provisions:

(1) That neither the panels nor the hearing officer have authority to formulate policies or procedures or to alter existing policies or procedures;

(2) That panels and the hearing officer have the discretion to determine the propriety of attendance at the hearing of persons not having a direct interest in the hearing, and, at the request of either party, the hearing shall be private;

(3) That the local government provide the panel or hearing officer with copies of the grievance

record prior to the hearing, and provide the grievant with a list of the documents furnished to the panel or hearing officer, and the grievant and his attorney, at least 10 days prior to the scheduled hearing, shall be allowed access to and copies of all relevant files intended to be used in the grievance proceeding;

(4) That panels and hearing officers have the authority to determine the admissibility of evidence without regard to the burden of proof, or the order of presentation of evidence, so long as a full and equal opportunity is afforded to all parties for the presentation of their evidence;

(5) That all evidence be presented in the presence of the panel or hearing officer and the parties, except by mutual consent of the parties;

(6) That documents, exhibits and lists of witnesses be exchanged between the parties or hearing officer in advance of the hearing;

(7) That the majority decision of the panel or the decision of the hearing officer, acting within the scope of its or his authority, be final, subject to existing policies, procedures and law;

(8) That the panel or hearing officer's decision be provided within a specified time to all parties; and

(9) Such other provisions as may facilitate fair and expeditious hearings, with the understanding that the hearings are not intended to be conducted like proceedings in courts, and that rules of evidence do not necessarily apply.

11. Implementation of final hearing decisions.

Either party may petition the circuit court having jurisdiction in the locality in which the grievant is employed for an order requiring implementation of the hearing decision.

B. Notwithstanding the contrary provisions of this section, a final hearing decision rendered under the provisions of this section that would result in the reinstatement of any employee of a sheriff's office who has been terminated for cause may be reviewed by the circuit court for the locality upon the petition of the locality. The review of the circuit court shall be limited to the question of whether the decision of the panel or hearing officer was consistent with provisions of law and written policy.

§ 15.2-1604. Appointment of deputies and employment of employees; discriminatory practices by certain officers; civil penalty.

A. It shall be an unlawful employment practice for a constitutional officer:

1. To fail or refuse to appoint or hire or to discharge any individual, or otherwise to discriminate against any individual with respect to his compensation, terms, conditions, or privileges of appointment or employment, because of such individual's race, color, religion, sex, age, marital status, pregnancy, childbirth or related medical conditions, sexual orientation, gender identity, national origin, ~~or~~ military status, *or COVID-19 vaccination status*; or

2. To limit, segregate, or classify his appointees, employees, or applicants for appointment or employment in any way that would deprive or tend to deprive any individual of employment opportunities or otherwise adversely affect his status as an employee, because of the individual's race, color, religion, sex, age, marital status, pregnancy, childbirth or related medical conditions, sexual orientation, gender identity, national origin, ~~or~~ military status, *or COVID-19 vaccination status*.

B. Nothing in this section shall be construed to make it an unlawful employment practice for a constitutional officer to hire or appoint an individual on the basis of his sex or age in those instances where sex or age is a bona fide occupational qualification reasonably necessary to the normal operation of that particular office. The provisions of this section shall not apply to policy-making positions, confidential or personal staff positions, or undercover positions.

C. With regard to notices and advertisements:

1. Every constitutional officer shall, prior to hiring any employee, advertise such employment position in a newspaper having general circulation or a state or local government job placement service in such constitutional officer's locality except where the vacancy is to be used (i) as a placement opportunity for appointees or employees affected by layoff, (ii) as a transfer opportunity or demotion for an incumbent, (iii) to fill positions that have been advertised within the past 120 days, (iv) to fill positions to be filled by appointees or employees returning from leave with or without pay, (v) to fill temporary positions, temporary employees being those employees hired to work on special projects that have durations of three months or less, or (vi) to fill policy-making positions, confidential or personal staff positions, or special, sensitive law-enforcement positions normally regarded as undercover work.

2. No constitutional officer shall print or publish or cause to be printed or published any notice or advertisement relating to employment by such constitutional officer indicating any preference, limitation, specification, or discrimination, based on sex or national origin, except that such notice or advertisement may indicate a preference, limitation, specification, or discrimination based on sex or age when sex or age is a bona fide occupational qualification for employment.

D. Complaints regarding violations of subsection A may be made to the Office of Civil Rights of the Department of Law. The Office shall have the authority to exercise its powers as provided in Article 4 (§ 2.2-520 et seq.) of Chapter 5 of Title 2.2.

E. Any constitutional officer who willfully violates the provisions of subsection C shall be subject to

a civil penalty not to exceed $2,000.

F. As used in this section, "military status" means status as (i) a member of the uniformed forces, as defined in 10 U.S.C. § 101(a)(5), of the United States or a reserve component thereof named under 10 U.S.C. § 10101, (ii) a veteran as defined in 38 U.S.C. § 101(2), or (iii) a dependent as defined in 50 U.S.C. § 3911(4) except that the support provided by the service member to the individual shall have been provided 180 days immediately preceding an alleged action that if proven true would constitute unlawful discrimination under this section instead of 180 days immediately preceding an application for relief under 50 U.S.C. Chapter 50.

§ 22.1-271.2. Immunization requirements.

A. No student shall be admitted by a school unless at the time of admission the student or his parent submits documentary proof of immunization to the admitting official of the school or unless the student is exempted from immunization pursuant to subsection C or is a homeless child or youth as defined in subdivision A 7 of § 22.1-3. If a student does not have documentary proof of immunization, the school shall notify the student or his parent (i) that it has no documentary proof of immunization for the student; (ii) that it may not admit the student without proof unless the student is exempted pursuant to subsection C, including any homeless child or youth as defined in subdivision A 7 of § 22.1-3; (iii) that the student may be immunized and receive certification by a licensed physician, licensed nurse practitioner, registered nurse or an employee of a local health department; and (iv) how to contact the local health department to learn where and when it performs these services. Neither this Commonwealth nor any school or admitting official shall be liable in damages to any person for complying with this section.

Any physician, nurse practitioner, registered nurse or local health department employee performing immunizations shall provide to any person who has been immunized or to his parent, upon request, documentary proof of immunizations conforming with the requirements of this section.

B. Any student whose immunizations are incomplete may be admitted conditionally if that student provides documentary proof at the time of enrollment of having received at least one dose of the required immunizations accompanied by a schedule for completion of the required doses within 90 calendar days. If the student requires more than two doses of hepatitis B vaccine, the conditional enrollment period shall be 180 calendar days.

The immunization record of each student admitted conditionally shall be reviewed periodically until the required immunizations have been received.

Any student admitted conditionally and who fails to comply with his schedule for completion of the required immunizations shall be excluded from school until his immunizations are resumed.

C. No certificate of immunization shall be required for the admission to school of any student if (i) the student or his parent submits an affidavit to the admitting official stating that the administration of immunizing agents conflicts with the student's religious tenets or practices; or (ii) the school has written certification from a licensed physician, licensed nurse practitioner, or local health department that one or more of the required immunizations may be detrimental to the student's health, indicating the specific nature and probable duration of the medical condition or circumstance that contraindicates immunization.

However, if a student is a homeless child or youth as defined in subdivision A 7 of § 22.1-3 and (a) does not have documentary proof of necessary immunizations or has incomplete immunizations and (b) is not exempted from immunization pursuant to ~~clauses~~ *clause* (i) or (ii) of this subsection, the school division shall immediately admit such student and shall immediately refer the student to the local school division liaison, as described in the federal McKinney-Vento Homeless Education Assistance Improvements Act of 2001, as amended (42 U.S.C. § 11431 et seq.) (the Act), who shall assist in obtaining the documentary proof of, or completing, immunization and other services required by such Act.

D. The admitting official of a school shall exclude from the school any student for whom he does not have documentary proof of immunization or notice of exemption pursuant to subsection C, including notice that such student is a homeless child or youth as defined in subdivision A 7 of § 22.1-3.

E. Every school shall record each student's immunizations on the school immunization record. The school immunization record shall be a standardized form provided by the State Department of Health, which shall be a part of the mandatory permanent student record. Such record shall be open to inspection by officials of the State Department of Health and the local health departments.

The school immunization record shall be transferred by the school whenever the school transfers any student's permanent academic or scholastic records.

Within 30 calendar days after the beginning of each school year or entrance of a student, each admitting official shall file a report with the local health department. The report shall be filed on forms prepared by the State Department of Health and shall state the number of students admitted to school with documentary proof of immunization, the number of students who have been admitted with a medical or religious exemption and the number of students who have been conditionally admitted,

including those students who are homeless children or youths as defined in subdivision A 7 of § 22.1-3.

F. The requirement for Haemophilus Influenzae Type b immunization as provided in § 32.1-46 shall not apply to any child admitted to any grade level, kindergarten through grade 12.

G. *Notwithstanding any other provision of law, no student shall be required to receive any COVID-19 vaccination.*

H. The Board of Health shall promulgate rules and regulations for the implementation of this section in congruence with rules and regulations of the Board of Health promulgated under § 32.1-46 and in cooperation with the Board of Education.

§ 22.1-271.4. Health requirements for home-instructed, exempted, and excused children.

In addition to compliance with the requirements of subsection B, D, or I of § 22.1-254 or § 22.1-254.1, any parent, guardian or other person having control or charge of a child being home instructed, exempted or excused from school attendance shall comply with the immunization requirements provided in § 32.1-46 in the same manner and to the same extent as if the child has been enrolled in and is attending school.

Upon request by the division superintendent, the parent shall submit to such division superintendent documentary proof of immunization in compliance with § 32.1-46.

No proof of immunization shall be required of any child upon submission of (i) an affidavit to the division superintendent stating that the administration of immunizing agents conflicts with the parent's or guardian's religious tenets or practices or (ii) a written certification from a licensed physician, licensed nurse practitioner, or local health department that one or more of the required immunizations may be detrimental to the child's health, indicating the specific nature of the medical condition or circumstance that contraindicates immunization.

Notwithstanding any other provision of law, no student shall be required to receive any COVID-19 vaccination.

§ 22.1-289.031. Child day center operated by religious institution exempt from licensure; annual statement and documentary evidence required; enforcement; injunctive relief.

A. Notwithstanding any other provisions of this chapter, a child day center, including a child day center operated or conducted under the auspices of a religious institution, shall be exempt from the licensure requirements of this chapter, but shall comply with the provisions of this section unless it chooses to be licensed. If such religious institution chooses not to be licensed, it shall file with the Superintendent, prior to beginning operation of a child day center and thereafter annually, a statement of intent to operate a child day center, certification that the child day center has disclosed in writing to the parents or guardians of the children in the center the fact that it is exempt from licensure and has posted the fact that it is exempt from licensure in a visible location on the premises, the qualifications of the personnel employed therein, and documentary evidence that:

1. Such religious institution has tax exempt status as a nonprofit religious institution in accordance with § 501(c) of the Internal Revenue Code of 1954, as amended, or that the real property owned and exclusively occupied by the religious institution is exempt from local taxation.

2. Within the prior 90 days for the initial exemption and within the prior 180 days for exemptions thereafter, the local health department and local fire marshal or Office of the State Fire Marshal, whichever is appropriate, have inspected the physical facilities of the child day center and have determined that the center is in compliance with applicable laws and regulations with regard to food service activities, health and sanitation, water supply, building codes, and the Statewide Fire Prevention Code or the Uniform Statewide Building Code.

3. The child day center employs supervisory personnel according to the following ratio of staff to children:

a. One staff member to four children from ages zero to 16 months.

b. One staff member to five children from ages 16 months to 24 months.

c. One staff member to eight children from ages 24 months to 36 months.

d. One staff member to 10 children from ages 36 months to five years.

e. One staff member to 20 children from ages five years to nine years.

f. One staff member to 25 children from ages nine years to 12 years.

Staff shall be counted in the required staff-to-children ratios only when they are directly supervising children. When a group of children receiving care includes children from different age brackets, the age of the youngest child in the group shall be used to determine the staff-to-children ratio that applies to that group. For each group of children receiving care, at least one adult staff member shall be regularly present. However, during designated daily rest periods and designated sleep periods of evening and overnight care programs, for children ages 16 months to six years, only one staff member shall be required to be present with the children under supervision. In such cases, at least one staff member shall be physically present in the same space as the children under supervision at all times. Other staff members counted for purposes of the staff-to-child ratio need not be physically present in the same space as the resting or sleeping children, but shall be present on the same floor as the resting or

sleeping children and shall have no barrier to their immediate access to the resting or sleeping children. The staff member who is physically present in the same space as the sleeping children shall be able to summon additional staff counted in the staff-to-child ratio without leaving the space in which the resting or sleeping children are located.

Staff members shall be at least 16 years of age. Staff members under 18 years of age shall be under the supervision of an adult staff member. Adult staff members shall supervise no more than two staff members under 18 years of age at any given time.

4. Each person in a supervisory position has been certified by a practicing physician or physician assistant to be free from any disability which would prevent him from caring for children under his supervision.

5. The center is in compliance with the requirements of:

a. This section.

b. Section 22.1-289.039 relating to background checks.

c. Section 63.2-1509 relating to the reporting of suspected cases of child abuse and neglect.

d. Chapter 3 (§ 46.2-300 et seq.) of Title 46.2 regarding a valid Virginia driver's license or commercial driver's license; Article 21 (§ 46.2-1157 et seq.) of Chapter 10 of Title 46.2, regarding vehicle inspections; ensuring that any vehicle used to transport children is an insured motor vehicle as defined in § 46.2-705; and Article 13 (§ 46.2-1095 et seq.) of Chapter 10 of Title 46.2, regarding child restraint devices.

6. The following aspects of the child day center's operations are described in a written statement provided to the parents or guardians of the children in the center and made available to the general public: physical facilities, enrollment capacity, food services, health requirements for the staff, and public liability insurance.

7. The individual seeking to operate the child day center is not currently ineligible to operate another child day program due to a suspension or revocation of his license or license exemption for reasons involving child safety or any criminal conviction, including fraud, related to such child day program.

8. A person trained and certified in first aid and cardiopulmonary resuscitation (CPR) will be present at the child day center whenever children are present or at any other location in which children attending the child day center are present.

9. The child day center is in compliance with all safe sleep guidelines recommended by the American Academy of Pediatrics.

B. The center shall establish and implement procedures for:

1. Hand washing by staff and children before eating and after toileting and diapering.

2. Appropriate supervision of all children in care, including daily intake and dismissal procedures to ensure safety of children.

3. A daily simple health screening and exclusion of sick children by a person trained to perform such screenings.

4. Ensuring that all children in the center are in compliance with the provisions of § 32.1-46 regarding the immunization of children against certain diseases, *except that no child shall be required to receive any COVID-19 vaccination*.

5. Ensuring that all areas of the premises accessible to children are free of obvious injury hazards, including providing and maintaining sand or other cushioning material under playground equipment.

6. Ensuring that all staff are able to recognize the signs of child abuse and neglect.

7. Ensuring that all incidents involving serious physical injury to or death of children attending the child day center are reported to the Superintendent. Reports of serious physical injuries, which shall include any physical injuries that require an emergency referral to an offsite health care professional or treatment in a hospital, shall be submitted annually. Reports of deaths shall be submitted no later than one business day after the death occurred.

C. The Superintendent may perform on-site inspections of religious institutions to confirm compliance with the provisions of this section and to investigate complaints that the religious institution is not in compliance with the provisions of this section. The Superintendent may revoke the exemption for any child day center in serious or persistent violation of the requirements of this section. If a religious institution operates a child day center and does not file the statement and documentary evidence required by this section, the Superintendent shall give reasonable notice to such religious institution of the nature of its noncompliance and may thereafter take such action as he determines appropriate, including a suit to enjoin the operation of the child day center.

D. Any person who has reason to believe that a child day center falling within the provisions of this section is not in compliance with the requirements of this section may report the same to the Department, the local health department, or the local fire marshal, each of which may inspect the child day center for noncompliance, give reasonable notice to the religious institution, and thereafter may take appropriate action as provided by law, including a suit to enjoin the operation of the child day center.

E. Nothing in this section shall prohibit a child day center operated by or conducted under the auspices of a religious institution from obtaining a license pursuant to this chapter.

§ 22.1-295.2. Employment discrimination prohibited.

A. As used in this section:

"Age" means being an individual who is at least 40 years of age.

"Military status" means status as (i) a member of the uniformed forces, as defined in 10 U.S.C. § 101(a)(5), of the United States or a reserve component thereof named under 10 U.S.C. § 10101, (ii) a veteran as defined in 38 U.S.C. § 101(2), or (iii) a dependent as defined in 50 U.S.C. § 3911(4) except that the support provided by the service member to the individual shall have been provided 180 days immediately preceding an alleged action that if proven true would constitute unlawful discrimination under this section instead of 180 days immediately preceding an application for relief under 50 U.S.C. Chapter 50.

B. No school board or any agent or employee thereof shall discriminate in employment on the basis of race, color, religion, national origin, sex, pregnancy, childbirth or related medical conditions, age, marital status, disability, sexual orientation, gender identity, ~~or~~ military status*, or COVID-19 vaccination status*.

C. The provisions of this section shall not prohibit (i) discrimination in employment on the basis of sex or age in those instances when sex or age is a bona fide occupational qualification for employment or (ii) providing preference in employment to veterans.

§ 22.1-306. Definitions.

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

"Business day" means any day that the relevant school board office is open.

"Day" means calendar days unless a different meaning is clearly expressed in this article. Whenever the last day for performing an act required by this article falls on a Saturday, Sunday, or legal holiday, the act may be performed on the next day that is not a Saturday, Sunday, or legal holiday.

"Dismissal" means the dismissal of any teacher during the term of such teacher's contract.

"Grievance" means a complaint or dispute by a teacher relating to his employment, including (i) disciplinary action including dismissal; (ii) the application or interpretation of (a) personnel policies, (b) procedures, (c) rules and regulations, (d) ordinances, and (e) statutes; (iii) acts of reprisal against a teacher for filing or processing a grievance, participating as a witness in any step, meeting, or hearing relating to a grievance, or serving as a member of a fact-finding panel; and (iv) complaints of discrimination on the basis of race, color, creed, religion, political affiliation, disability, age, national origin, sex, pregnancy, childbirth or related medical conditions, marital status, sexual orientation, gender identity, ~~or~~ military status*, or COVID-19 vaccination status*. Each school board shall have the exclusive right to manage the affairs and operations of the school division. Accordingly, the term "grievance" shall not include a complaint or dispute by a teacher relating to (a) establishment and revision of wages or salaries, position classifications, or general benefits; (b) suspension of a teacher or nonrenewal of the contract of a teacher who has not achieved continuing contract status; (c) the establishment or contents of ordinances, statutes, or personnel policies, procedures, rules, and regulations; (d) failure to promote; (e) discharge, layoff, or suspension from duties because of decrease in enrollment, decrease in enrollment or abolition of a particular subject, or insufficient funding; (f) hiring, transfer, assignment, and retention of teachers within the school division; (g) suspension from duties in emergencies; (h) the methods, means, and personnel by which the school division's operations are to be carried on; or (i) coaching or extracurricular activity sponsorship.

While these management rights are reserved to the school board, failure to apply, where applicable, the rules, regulations, policies, or procedures as written or established by the school board is grievable.

"Military status" means status as (i) a member of the uniformed forces, as defined in 10 U.S.C. § 101(a)(5), of the United States or a reserve component thereof named under 10 U.S.C. § 10101, (ii) a veteran as defined in 38 U.S.C. § 101(2), or (iii) a dependent as defined in 50 U.S.C. § 3911(4) except that the support provided by the service member to the individual shall have been provided 180 days immediately preceding an alleged action that if proven true would constitute unlawful discrimination under this section instead of 180 days immediately preceding an application for relief under 50 U.S.C. Chapter 50.

§ 23.1-800. Health histories and immunizations required; exemptions.

A. No full-time student who enrolls for the first time in any baccalaureate public institution of higher education is eligible to register for his second semester or quarter unless he (i) has furnished, before the beginning of the second semester or quarter of enrollment, a health history consistent with guidelines adopted by each institution's board of visitors that includes documented evidence, provided by a licensed health professional or health facility, of the diseases for which the student has been immunized, the numbers of doses given, the date on which the immunization was administered, and any further immunizations indicated or (ii) objects to such health history requirement on religious grounds, in which case he is exempt from such requirement.

B. Prior to enrollment for the first time in any baccalaureate public institution of higher education, each student shall be immunized by vaccine against diphtheria, tetanus, poliomyelitis, measles (rubeola), German measles (rubella), and mumps according to the guidelines of the American College Health Association.

C. Prior to enrollment for the first time in any baccalaureate public institution of higher education, each full-time student shall be vaccinated against meningococcal disease and hepatitis B unless the student or, if the student is a minor, the student's parent or legal guardian signs a written waiver stating that he has received and reviewed detailed information on the risks associated with meningococcal disease and hepatitis B and the availability and effectiveness of any vaccine and has chosen not to be or not to have the student vaccinated.

D. Any student is exempt from the immunization requirements set forth in subsections B and C who (i) objects on the grounds that administration of immunizing agents conflicts with his religious tenets or practices~~, unless the Board of Health has declared an emergency or epidemic of disease,~~ or (ii) presents a statement from a licensed physician that states that his physical condition is such that administration of one or more of the required immunizing agents would be detrimental to his health.

E. The Board and Commissioner of Health shall cooperate with any board of visitors seeking assistance in the implementation of this section.

F. The Council shall, in cooperation with the Board and Commissioner of Health, encourage private institutions of higher education to develop a procedure for providing information about the risks associated with meningococcal disease and hepatitis B and the availability and effectiveness of any vaccine against meningococcal disease and hepatitis B.

§ 32.1-15.2. Board not authorized to require COVID-19 vaccination over religious objection.

Notwithstanding any other provision of law, the Board shall not require any person to receive any COVID-19 vaccination.

§ 32.1-43. Authority of State Health Commissioner to require quarantine, etc.

The State Health Commissioner shall have the authority to require quarantine, isolation, immunization, decontamination, or treatment of any individual or group of individuals when he determines any such measure to be necessary to control the spread of any disease of public health importance and the authority to issue orders of isolation pursuant to Article 3.01 (§ 32.1-48.01 et seq.) ~~of this chapter~~ and orders of quarantine and orders of isolation under exceptional circumstances involving any communicable disease of public health threat pursuant to Article 3.02 (§ 32.1-48.05 et seq.) ~~of this chapter~~*, except that the Commissioner shall not have the authority to require immunization of any person against COVID-19.*

§ 32.1-47. Exclusion from school of children not immunized.

Upon the identification of an outbreak, potential epidemic or epidemic of a vaccine-preventable disease in a public or private school, the Commissioner shall have the authority to require the exclusion from such school of all children who are not immunized against that disease*, except that the Commissioner shall not have the authority to exclude from such school children who are not immunized against COVID-19.*

§ 32.1-47.1. Vaccination of children; plan enhancements.

A. The Department shall include in its vaccination plans procedures to ensure the prompt vaccination of all persons of school age in the Commonwealth, without preference regarding the manner of compliance with the compulsory school attendance law set forth in § 22.1-254, upon declaration of a public health emergency involving a vaccine-preventable disease and consent of the parent or guardian of the person of school age if such person is a minor or, if the person of school age is not a minor, of the person. Vaccination plans developed pursuant to this section shall be consistent with applicable guidelines developed by the Centers for Disease Control and Prevention, and shall be subject to the same review and update requirements, process, and schedule as the State Emergency Operations Plan developed by the Department of Emergency Management pursuant to § 44-146.18.

B. Notwithstanding the provisions of subsection A or any other provision of law, no person shall be required to receive any COVID-19 vaccination.

§ 32.1-48. Powers of Commissioner in epidemic.

A. ~~Nothing in this article shall preclude the Commissioner from requiring immediate immunization of all persons in case of an epidemic of any disease of public health importance for which a vaccine exists other than a person to whose health the administration of a vaccine would be detrimental as certified in writing by a physician licensed to practice medicine in this Commonwealth.~~

~~B. In addition, the~~ *The* State Health Commissioner shall hold the powers conferred pursuant to Article 3.02 (§ 32.1-48.05 et seq.) ~~of this chapter~~ to issue orders of quarantine or prepare orders of isolation for a communicable disease of public health threat.

B. Notwithstanding any other provision of law, the Commissioner shall not hold the power to require any person to receive any immunization against COVID-19.

§ 32.1-48.002. Immunizations not required.

Notwithstanding any other provision of law, no person shall be required to receive any immunization against COVID-19 and no person shall be (i) discriminated against with regard to the provision of any disposition, service, financial benefit, eligibility, admission, enrollment, participation, membership, or other benefit, (ii) subjected to segregation or separate treatment, or (iii) restricted in any way in the enjoyment of any advantage or privilege enjoyed by any other person receiving any disposition, service, financial benefit, eligibility, admission, enrollment, participation, membership, or other benefit.

§ 32.1-127. Regulations.

A. The regulations promulgated by the Board to carry out the provisions of this article shall be in substantial conformity to the standards of health, hygiene, sanitation, construction and safety as established and recognized by medical and health care professionals and by specialists in matters of public health and safety, including health and safety standards established under provisions of Title XVIII and Title XIX of the Social Security Act, and to the provisions of Article 2 (§ 32.1-138 et seq.).

B. Such regulations:

1. Shall include minimum standards for (i) the construction and maintenance of hospitals, nursing homes and certified nursing facilities to ensure the environmental protection and the life safety of its patients, employees, and the public; (ii) the operation, staffing and equipping of hospitals, nursing homes and certified nursing facilities; (iii) qualifications and training of staff of hospitals, nursing homes and certified nursing facilities, except those professionals licensed or certified by the Department of Health Professions; (iv) conditions under which a hospital or nursing home may provide medical and nursing services to patients in their places of residence; and (v) policies related to infection prevention, disaster preparedness, and facility security of hospitals, nursing homes, and certified nursing facilities;

2. Shall provide that at least one physician who is licensed to practice medicine in this Commonwealth shall be on call at all times, though not necessarily physically present on the premises, at each hospital which operates or holds itself out as operating an emergency service;

3. May classify hospitals and nursing homes by type of specialty or service and may provide for licensing hospitals and nursing homes by bed capacity and by type of specialty or service;

4. Shall also require that each hospital establish a protocol for organ donation, in compliance with federal law and the regulations of the Centers for Medicare and Medicaid Services (CMS), particularly 42 C.F.R. § 482.45. Each hospital shall have an agreement with an organ procurement organization designated in CMS regulations for routine contact, whereby the provider's designated organ procurement organization certified by CMS (i) is notified in a timely manner of all deaths or imminent deaths of patients in the hospital and (ii) is authorized to determine the suitability of the decedent or patient for organ donation and, in the absence of a similar arrangement with any eye bank or tissue bank in Virginia certified by the Eye Bank Association of America or the American Association of Tissue Banks, the suitability for tissue and eye donation. The hospital shall also have an agreement with at least one tissue bank and at least one eye bank to cooperate in the retrieval, processing, preservation, storage, and distribution of tissues and eyes to ensure that all usable tissues and eyes are obtained from potential donors and to avoid interference with organ procurement. The protocol shall ensure that the hospital collaborates with the designated organ procurement organization to inform the family of each potential donor of the option to donate organs, tissues, or eyes or to decline to donate. The individual making contact with the family shall have completed a course in the methodology for approaching potential donor families and requesting organ or tissue donation that (a) is offered or approved by the organ procurement organization and designed in conjunction with the tissue and eye bank community and (b) encourages discretion and sensitivity according to the specific circumstances, views, and beliefs of the relevant family. In addition, the hospital shall work cooperatively with the designated organ procurement organization in educating the staff responsible for contacting the organ procurement organization's personnel on donation issues, the proper review of death records to improve identification of potential donors, and the proper procedures for maintaining potential donors while necessary testing and placement of potential donated organs, tissues, and eyes takes place. This process shall be followed, without exception, unless the family of the relevant decedent or patient has expressed opposition to organ donation, the chief administrative officer of the hospital or his designee knows of such opposition, and no donor card or other relevant document, such as an advance directive, can be found;

5. Shall require that each hospital that provides obstetrical services establish a protocol for admission or transfer of any pregnant woman who presents herself while in labor;

6. Shall also require that each licensed hospital develop and implement a protocol requiring written discharge plans for identified, substance-abusing, postpartum women and their infants. The protocol shall require that the discharge plan be discussed with the patient and that appropriate referrals for the mother and the infant be made and documented. Appropriate referrals may include, but need not be limited to, treatment services, comprehensive early intervention services for infants and toddlers with disabilities and their families pursuant to Part H of the Individuals with Disabilities Education Act, 20 U.S.C. § 1471 et seq., and family-oriented prevention services. The discharge planning process shall involve, to

the extent possible, the other parent of the infant and any members of the patient's extended family who may participate in the follow-up care for the mother and the infant. Immediately upon identification, pursuant to § 54.1-2403.1, of any substance-abusing, postpartum woman, the hospital shall notify, subject to federal law restrictions, the community services board of the jurisdiction in which the woman resides to appoint a discharge plan manager. The community services board shall implement and manage the discharge plan;

7. Shall require that each nursing home and certified nursing facility fully disclose to the applicant for admission the home's or facility's admissions policies, including any preferences given;

8. Shall require that each licensed hospital establish a protocol relating to the rights and responsibilities of patients which shall include a process reasonably designed to inform patients of such rights and responsibilities. Such rights and responsibilities of patients, a copy of which shall be given to patients on admission, shall be consistent with applicable federal law and regulations of the Centers for Medicare and Medicaid Services;

9. Shall establish standards and maintain a process for designation of levels or categories of care in neonatal services according to an applicable national or state-developed evaluation system. Such standards may be differentiated for various levels or categories of care and may include, but need not be limited to, requirements for staffing credentials, staff/patient ratios, equipment, and medical protocols;

10. Shall require that each nursing home and certified nursing facility train all employees who are mandated to report adult abuse, neglect, or exploitation pursuant to § 63.2-1606 on such reporting procedures and the consequences for failing to make a required report;

11. Shall permit hospital personnel, as designated in medical staff bylaws, rules and regulations, or hospital policies and procedures, to accept emergency telephone and other verbal orders for medication or treatment for hospital patients from physicians, and other persons lawfully authorized by state statute to give patient orders, subject to a requirement that such verbal order be signed, within a reasonable period of time not to exceed 72 hours as specified in the hospital's medical staff bylaws, rules and regulations or hospital policies and procedures, by the person giving the order, or, when such person is not available within the period of time specified, co-signed by another physician or other person authorized to give the order;

12. Shall require, unless the vaccination is medically contraindicated or the resident declines the offer of the vaccination, that each certified nursing facility and nursing home provide or arrange for the administration to its residents of (i) an annual vaccination against influenza and (ii) a pneumococcal vaccination, in accordance with the most recent recommendations of the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;

13. Shall require that each nursing home and certified nursing facility register with the Department of State Police to receive notice of the registration, reregistration, or verification of registration information of any person required to register with the Sex Offender and Crimes Against Minors Registry pursuant to Chapter 9 (§ 9.1-900 et seq.) of Title 9.1 within the same or a contiguous zip code area in which the home or facility is located, pursuant to § 9.1-914;

14. Shall require that each nursing home and certified nursing facility ascertain, prior to admission, whether a potential patient is required to register with the Sex Offender and Crimes Against Minors Registry pursuant to Chapter 9 (§ 9.1-900 et seq.) of Title 9.1, if the home or facility anticipates the potential patient will have a length of stay greater than three days or in fact stays longer than three days;

15. Shall require that each licensed hospital include in its visitation policy a provision allowing each adult patient to receive visits from any individual from whom the patient desires to receive visits, subject to other restrictions contained in the visitation policy including, but not limited to, those related to the patient's medical condition and the number of visitors permitted in the patient's room simultaneously;

16. Shall require that each nursing home and certified nursing facility shall, upon the request of the facility's family council, send notices and information about the family council mutually developed by the family council and the administration of the nursing home or certified nursing facility, and provided to the facility for such purpose, to the listed responsible party or a contact person of the resident's choice up to six times per year. Such notices may be included together with a monthly billing statement or other regular communication. Notices and information shall also be posted in a designated location within the nursing home or certified nursing facility. No family member of a resident or other resident representative shall be restricted from participating in meetings in the facility with the families or resident representatives of other residents in the facility;

17. Shall require that each nursing home and certified nursing facility maintain liability insurance coverage in a minimum amount of $1 million, and professional liability coverage in an amount at least equal to the recovery limit set forth in § 8.01-581.15, to compensate patients or individuals for injuries and losses resulting from the negligent or criminal acts of the facility. Failure to maintain such

minimum insurance shall result in revocation of the facility's license;

18. Shall require each hospital that provides obstetrical services to establish policies to follow when a stillbirth, as defined in § 32.1-69.1, occurs that meet the guidelines pertaining to counseling patients and their families and other aspects of managing stillbirths as may be specified by the Board in its regulations;

19. Shall require each nursing home to provide a full refund of any unexpended patient funds on deposit with the facility following the discharge or death of a patient, other than entrance-related fees paid to a continuing care provider as defined in § 38.2-4900, within 30 days of a written request for such funds by the discharged patient or, in the case of the death of a patient, the person administering the person's estate in accordance with the Virginia Small Estates Act (§ 64.2-600 et seq.);

20. Shall require that each hospital that provides inpatient psychiatric services establish a protocol that requires, for any refusal to admit (i) a medically stable patient referred to its psychiatric unit, direct verbal communication between the on-call physician in the psychiatric unit and the referring physician, if requested by such referring physician, and prohibits on-call physicians or other hospital staff from refusing a request for such direct verbal communication by a referring physician and (ii) a patient for whom there is a question regarding the medical stability or medical appropriateness of admission for inpatient psychiatric services due to a situation involving results of a toxicology screening, the on-call physician in the psychiatric unit to which the patient is sought to be transferred to participate in direct verbal communication, either in person or via telephone, with a clinical toxicologist or other person who is a Certified Specialist in Poison Information employed by a poison control center that is accredited by the American Association of Poison Control Centers to review the results of the toxicology screen and determine whether a medical reason for refusing admission to the psychiatric unit related to the results of the toxicology screen exists, if requested by the referring physician;

21. Shall require that each hospital that is equipped to provide life-sustaining treatment shall develop a policy governing determination of the medical and ethical appropriateness of proposed medical care, which shall include (i) a process for obtaining a second opinion regarding the medical and ethical appropriateness of proposed medical care in cases in which a physician has determined proposed care to be medically or ethically inappropriate; (ii) provisions for review of the determination that proposed medical care is medically or ethically inappropriate by an interdisciplinary medical review committee and a determination by the interdisciplinary medical review committee regarding the medical and ethical appropriateness of the proposed health care; and (iii) requirements for a written explanation of the decision reached by the interdisciplinary medical review committee, which shall be included in the patient's medical record. Such policy shall ensure that the patient, his agent, or the person authorized to make medical decisions pursuant to § 54.1-2986 (a) are informed of the patient's right to obtain his medical record and to obtain an independent medical opinion and (b) afforded reasonable opportunity to participate in the medical review committee meeting. Nothing in such policy shall prevent the patient, his agent, or the person authorized to make medical decisions pursuant to § 54.1-2986 from obtaining legal counsel to represent the patient or from seeking other remedies available at law, including seeking court review, provided that the patient, his agent, or the person authorized to make medical decisions pursuant to § 54.1-2986, or legal counsel provides written notice to the chief executive officer of the hospital within 14 days of the date on which the physician's determination that proposed medical treatment is medically or ethically inappropriate is documented in the patient's medical record;

22. Shall require every hospital with an emergency department to establish protocols to ensure that security personnel of the emergency department, if any, receive training appropriate to the populations served by the emergency department, which may include training based on a trauma-informed approach in identifying and safely addressing situations involving patients or other persons who pose a risk of harm to themselves or others due to mental illness or substance abuse or who are experiencing a mental health crisis;

23. Shall require that each hospital establish a protocol requiring that, before a health care provider arranges for air medical transportation services for a patient who does not have an emergency medical condition as defined in 42 U.S.C. § 1395dd(e)(1), the hospital shall provide the patient or his authorized representative with written or electronic notice that the patient (i) may have a choice of transportation by an air medical transportation provider or medically appropriate ground transportation by an emergency medical services provider and (ii) will be responsible for charges incurred for such transportation in the event that the provider is not a contracted network provider of the patient's health insurance carrier or such charges are not otherwise covered in full or in part by the patient's health insurance plan;

24. Shall establish an exemption, for a period of no more than 30 days, from the requirement to obtain a license to add temporary beds in an existing hospital or nursing home when the Commissioner has determined that a natural or man-made disaster has caused the evacuation of a hospital or nursing home and that a public health emergency exists due to a shortage of hospital or nursing home beds;

25. Shall establish protocols to ensure that any patient scheduled to receive an elective surgical procedure for which the patient can reasonably be expected to require outpatient physical therapy as a

follow-up treatment after discharge is informed that he (i) is expected to require outpatient physical therapy as a follow-up treatment and (ii) will be required to select a physical therapy provider prior to being discharged from the hospital;

26. Shall permit nursing home staff members who are authorized to possess, distribute, or administer medications to residents to store, dispense, or administer cannabis oil to a resident who has been issued a valid written certification for the use of cannabis oil in accordance with subsection B of § 54.1-3408.3 and has registered with the Board of Pharmacy;

27. Shall require each hospital with an emergency department to establish a protocol for the treatment and discharge of individuals experiencing a substance use-related emergency, which shall include provisions for (i) appropriate screening and assessment of individuals experiencing substance use-related emergencies to identify medical interventions necessary for the treatment of the individual in the emergency department and (ii) recommendations for follow-up care following discharge for any patient identified as having a substance use disorder, depression, or mental health disorder, as appropriate, which may include, for patients who have been treated for substance use-related emergencies, including opioid overdose, or other high-risk patients, (a) the dispensing of naloxone or other opioid antagonist used for overdose reversal pursuant to subsection X of § 54.1-3408 at discharge or (b) issuance of a prescription for and information about accessing naloxone or other opioid antagonist used for overdose reversal, including information about accessing naloxone or other opioid antagonist used for overdose reversal at a community pharmacy, including any outpatient pharmacy operated by the hospital, or through a community organization or pharmacy that may dispense naloxone or other opioid antagonist used for overdose reversal without a prescription pursuant to a statewide standing order. Such protocols may also provide for referrals of individuals experiencing a substance use-related emergency to peer recovery specialists and community-based providers of behavioral health services, or to providers of pharmacotherapy for the treatment of drug or alcohol dependence or mental health diagnoses;

28. During a public health emergency related to COVID-19, shall require each nursing home and certified nursing facility to establish a protocol to allow each patient to receive visits, consistent with guidance from the Centers for Disease Control and Prevention and as directed by the Centers for Medicare and Medicaid Services and the Board. Such protocol shall include provisions describing (i) the conditions, including conditions related to the presence of COVID-19 in the nursing home, certified nursing facility, and community, under which in-person visits will be allowed and under which in-person visits will not be allowed and visits will be required to be virtual; (ii) the requirements with which in-person visitors will be required to comply to protect the health and safety of the patients and staff of the nursing home or certified nursing facility; (iii) the types of technology, including interactive audio or video technology, and the staff support necessary to ensure visits are provided as required by this subdivision; and (iv) the steps the nursing home or certified nursing facility will take in the event of a technology failure, service interruption, or documented emergency that prevents visits from occurring as required by this subdivision. Such protocol shall also include (a) a statement of the frequency with which visits, including virtual and in-person, where appropriate, will be allowed, which shall be at least once every 10 calendar days for each patient; (b) a provision authorizing a patient or the patient's personal representative to waive or limit visitation, provided that such waiver or limitation is included in the patient's health record; and (c) a requirement that each nursing home and certified nursing facility publish on its website or communicate to each patient or the patient's authorized representative, in writing or via electronic means, the nursing home's or certified nursing facility's plan for providing visits to patients as required by this subdivision;

29. Shall require each hospital, nursing home, and certified nursing facility to establish and implement policies to ensure the permissible access to and use of an intelligent personal assistant provided by a patient, in accordance with such regulations, while receiving inpatient services. Such policies shall ensure protection of health information in accordance with the requirements of the federal Health Insurance Portability and Accountability Act of 1996, 42 U.S.C. § 1320d et seq., as amended. For the purposes of this subdivision, "intelligent personal assistant" means a combination of an electronic device and a specialized software application designed to assist users with basic tasks using a combination of natural language processing and artificial intelligence, including such combinations known as "digital assistants" or "virtual assistants"; ~~and~~

30. During a declared public health emergency related to a communicable disease of public health threat, shall require each hospital, nursing home, and certified nursing facility to establish a protocol to allow patients to receive visits from a rabbi, priest, minister, or clergy of any religious denomination or sect consistent with guidance from the Centers for Disease Control and Prevention and the Centers for Medicare and Medicaid Services and subject to compliance with any executive order, order of public health, Department guidance, or any other applicable federal or state guidance having the effect of limiting visitation. Such protocol may restrict the frequency and duration of visits and may require visits to be conducted virtually using interactive audio or video technology. Any such protocol may require the

person visiting a patient pursuant to this subdivision to comply with all reasonable requirements of the hospital, nursing home, or certified nursing facility adopted to protect the health and safety of the person, patients, and staff of the hospital, nursing home, or certified nursing facility*; and*

31. Shall prohibit a hospital, nursing home, or certified nursing facility from requiring any person who is a patient at or employee of the hospital, nursing home, or certified nursing facility to receive any immunization against COVID-19.

C. Upon obtaining the appropriate license, if applicable, licensed hospitals, nursing homes, and certified nursing facilities may operate adult day care centers.

D. All facilities licensed by the Board pursuant to this article which provide treatment or care for hemophiliacs and, in the course of such treatment, stock clotting factors, shall maintain records of all lot numbers or other unique identifiers for such clotting factors in order that, in the event the lot is found to be contaminated with an infectious agent, those hemophiliacs who have received units of this contaminated clotting factor may be apprised of this contamination. Facilities which have identified a lot that is known to be contaminated shall notify the recipient's attending physician and request that he notify the recipient of the contamination. If the physician is unavailable, the facility shall notify by mail, return receipt requested, each recipient who received treatment from a known contaminated lot at the individual's last known address.

E. Hospitals in the Commonwealth may enter into agreements with the Department of Health for the provision to uninsured patients of naloxone or other opioid antagonists used for overdose reversal.

§ 37.2-205. Board not authorized to require vaccinations.

A. Notwithstanding any other provision of law, the Board shall not require any person to be immunized against COVID-19.

B. No person licensed by the Department shall deny any person services solely because such person has not been immunized against COVID-19.

§ 38.2-3100.4. Prohibited discrimination based on vaccination status.

No insurer issuing an individual or group life insurance policy in the Commonwealth shall refuse to insure an applicant or limit the amount, extent, or kind of coverage for an applicant solely on the basis of the applicant's COVID-19 vaccination status.

§ 38.2-3407.15. Ethics and fairness in carrier business practices.

A. As used in this section:

"Carrier," "enrollee," and "provider" shall have the meanings set forth in § 38.2-3407.10; however, a "carrier" shall also include any person required to be licensed under this title which offers or operates a managed care health insurance plan subject to Chapter 58 (§ 38.2-5800 et seq.) or which provides or arranges for the provision of health care services, health plans, networks or provider panels which are subject to regulation as the business of insurance under this title.

"Claim" means any bill, claim, or proof of loss made by or on behalf of an enrollee or a provider to a carrier (or its intermediary, administrator or representative) with which the provider has a provider contract for payment for health care services under any health plan; however, a "claim" shall not include a request for payment of a capitation or a withhold.

"Clean claim" means a claim (i) that has no material defect or impropriety (including any lack of any reasonably required substantiation documentation) which substantially prevents timely payment from being made on the claim or (ii) with respect to which a carrier has failed timely to notify the person submitting the claim of any such defect or impropriety in accordance with this section.

"Health care services" means items or services furnished to any individual for the purpose of preventing, alleviating, curing, or healing human illness, injury or physical disability.

"Health plan" means any individual or group health care plan, subscription contract, evidence of coverage, certificate, health services plan, medical or hospital services plan, accident and sickness insurance policy or certificate, managed care health insurance plan, or other similar certificate, policy, contract or arrangement, and any endorsement or rider thereto, to cover all or a portion of the cost of persons receiving covered health care services, which is subject to state regulation and which is required to be offered, arranged or issued in the Commonwealth by a carrier licensed under this title. Health plan does not mean (i) 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. (Medicaid) or Title XXI of the Social Security Act, 42 U.S.C. § 1397aa et seq. (CHIP), 5 U.S.C. § 8901 et seq. (federal employees), or 10 U.S.C. § 1071 et seq. (TRICARE); or (ii) accident only, credit or disability insurance, long-term care insurance, TRICARE supplement, Medicare supplement, or workers' compensation coverages.

"Provider contract" means any contract between a provider and a carrier (or a carrier's network, provider panel, intermediary or representative) relating to the provision of health care services.

"Retroactive denial of a previously paid claim" or "retroactive denial of payment" means any attempt by a carrier retroactively to collect payments already made to a provider with respect to a claim by reducing other payments currently owed to the provider, by withholding or setting off against future

payments, or in any other manner reducing or affecting the future claim payments to the provider.

B. Subject to subsection I, every provider contract entered into by a carrier shall contain specific provisions which shall require the carrier to adhere to and comply with the following minimum fair business standards in the processing and payment of claims for health care services:

1. A carrier shall pay any claim within 40 days of receipt of the claim except where the obligation of the carrier to pay a claim is not reasonably clear due to the existence of a reasonable basis supported by specific information available for review by the person submitting the claim that:

a. The claim is determined by the carrier not to be a clean claim due to a good faith determination or dispute regarding (i) the manner in which the claim form was completed or submitted, (ii) the eligibility of a person for coverage, (iii) the responsibility of another carrier for all or part of the claim, (iv) the amount of the claim or the amount currently due under the claim, (v) the benefits covered, or (vi) the manner in which services were accessed or provided; or

b. The claim was submitted fraudulently.

Each carrier shall maintain a written or electronic record of the date of receipt of a claim. The person submitting the claim shall be entitled to inspect such record on request and to rely on that record or on any other admissible evidence as proof of the fact of receipt of the claim, including without limitation electronic or facsimile confirmation of receipt of a claim.

2. A carrier shall, within 30 days after receipt of a claim, request electronically or in writing from the person submitting the claim the information and documentation that the carrier reasonably believes will be required to process and pay the claim or to determine if the claim is a clean claim. Upon receipt of the additional information requested under this subsection necessary to make the original claim a clean claim, a carrier shall make the payment of the claim in compliance with this section. No carrier may refuse to pay a claim for health care services rendered pursuant to a provider contract which are covered benefits if the carrier fails timely to notify or attempt to notify the person submitting the claim of the matters identified above unless such failure was caused in material part by the person submitting the claims; however, nothing herein shall preclude such a carrier from imposing a retroactive denial of payment of such a claim if permitted by the provider contract unless such retroactive denial of payment of the claim would violate subdivision 7. Nothing in this subsection shall require a carrier to pay a claim which is not a clean claim.

3. Any interest owing or accruing on a claim under § 38.2-3407.1 or 38.2-4306.1, under any provider contract or under any other applicable law, shall, if not sooner paid or required to be paid, be paid, without necessity of demand, at the time the claim is paid or within 60 days thereafter.

4. a. Every carrier shall establish and implement reasonable policies to permit any provider with which there is a provider contract (i) to confirm in advance during normal business hours by free telephone or electronic means if available whether the health care services to be provided are medically necessary and a covered benefit and (ii) to determine the carrier's requirements applicable to the provider (or to the type of health care services which the provider has contracted to deliver under the provider contract) for (a) pre-certification or authorization of coverage decisions, (b) retroactive reconsideration of a certification or authorization of coverage decision or retroactive denial of a previously paid claim, (c) provider-specific payment and reimbursement methodology, coding levels and methodology, downcoding, and bundling of claims, and (d) other provider-specific, applicable claims processing and payment matters necessary to meet the terms and conditions of the provider contract, including determining whether a claim is a clean claim. If a carrier routinely, as a matter of policy, bundles or downcodes claims submitted by a provider, the carrier shall clearly disclose that practice in each provider contract. Further, such carrier shall either (1) disclose in its provider contracts or on its website the specific bundling and downcoding policies that the carrier reasonably expects to be applied to the provider or provider's services on a routine basis as a matter of policy or (2) disclose in each provider contract a telephone or facsimile number or e-mail address that a provider can use to request the specific bundling and downcoding policies that the carrier reasonably expects to be applied to that provider or provider's services on a routine basis as a matter of policy. If such request is made by or on behalf of a provider, a carrier shall provide the requesting provider with such policies within 10 business days following the date the request is received.

b. Every carrier shall make available to such providers within 10 business days of receipt of a request, copies of or reasonable electronic access to all such policies which are applicable to the particular provider or to particular health care services identified by the provider. In the event the provision of the entire policy would violate any applicable copyright law, the carrier may instead comply with this subsection by timely delivering to the provider a clear explanation of the policy as it applies to the provider and to any health care services identified by the provider.

5. Every carrier shall pay a claim if the carrier has previously authorized the health care service or has advised the provider or enrollee in advance of the provision of health care services that the health care services are medically necessary and a covered benefit, unless:

a. The documentation for the claim provided by the person submitting the claim clearly fails to support the claim as originally authorized;

b. The carrier's refusal is because (i) another payor is responsible for the payment, (ii) the provider has already been paid for the health care services identified on the claim, (iii) the claim was submitted fraudulently or the authorization was based in whole or material part on erroneous information provided to the carrier by the provider, enrollee, or other person not related to the carrier, or (iv) the person receiving the health care services was not eligible to receive them on the date of service and the carrier did not know, and with the exercise of reasonable care could not have known, of the person's eligibility status; or

c. During the post-service claims process, it is determined that the claim was submitted fraudulently.

6. In the case of an invasive or surgical procedure, if the carrier has previously authorized a health care service as medically necessary and during the procedure the health care provider discovers clinical evidence prompting the provider to perform a less or more extensive or complicated procedure than was previously authorized, then the carrier shall pay the claim, provided that the additional procedures were (i) not investigative in nature, but medically necessary as a covered service under the covered person's benefit plan; (ii) appropriately coded consistent with the procedure actually performed; and (iii) compliant with a carrier's post-service claims process, including required timing for submission to carrier.

7. No carrier shall impose any retroactive denial of a previously paid claim unless the carrier has provided the reason for the retroactive denial and (i) the original claim was submitted fraudulently, (ii) the original claim payment was incorrect because the provider was already paid for the health care services identified on the claim or the health care services identified on the claim were not delivered by the provider, or (iii) the time which has elapsed since the date of the payment of the original challenged claim does not exceed the lesser of (a) 12 months or (b) the number of days within which the carrier requires under its provider contract that a claim be submitted by the provider following the date on which a health care service is provided. Effective July 1, 2000, a carrier shall notify a provider at least 30 days in advance of any retroactive denial of a claim.

8. Notwithstanding subdivision 7, with respect to provider contracts entered into, amended, extended, or renewed on or after July 1, 2004, no carrier shall impose any retroactive denial of payment or in any other way seek recovery or refund of a previously paid claim unless the carrier specifies in writing the specific claim or claims for which the retroactive denial is to be imposed or the recovery or refund is sought. The written communication shall also contain an explanation of why the claim is being retroactively adjusted.

9. No provider contract shall fail to include or attach at the time it is presented to the provider for execution (i) the fee schedule, reimbursement policy, or statement as to the manner in which claims will be calculated and paid that is applicable to the provider or to the range of health care services reasonably expected to be delivered by that type of provider on a routine basis and (ii) all material addenda, schedules, and exhibits thereto and any policies (including those referred to in subdivision 4) applicable to the provider or to the range of health care services reasonably expected to be delivered by that type of provider under the provider contract.

10. No amendment to any provider contract or to any addenda, schedule, exhibit or policy thereto (or new addenda, schedule, exhibit, or policy) applicable to the provider (or to the range of health care services reasonably expected to be delivered by that type of provider) shall be effective as to the provider, unless the provider has been provided with the applicable portion of the proposed amendment (or of the proposed new addenda, schedule, exhibit, or policy) at least 60 calendar days before the effective date and the provider has failed to notify the carrier within 30 calendar days of receipt of the documentation of the provider's intention to terminate the provider contract at the earliest date thereafter permitted under the provider contract.

11. In the event that the carrier's provision of a policy required to be provided under subdivision 9 or 10 would violate any applicable copyright law, the carrier may instead comply with this section by providing a clear, written explanation of the policy as it applies to the provider.

12. All carriers shall establish, in writing, their claims payment dispute mechanism and shall make this information available to providers.

13. Every carrier shall include in its provider contracts a provision that prohibits a provider from discriminating against any enrollee solely due to the enrollee's status as a litigant in pending litigation or a potential litigant due to being involved in a motor vehicle accident. Nothing in this subdivision shall require a health care provider to treat an enrollee who has threatened to make or has made a professional liability claim against the provider or the provider's employer, agents, or employees or has threatened to file or has filed a complaint with a regulatory agency or board against the provider or the provider's employer, agents, or employees.

14. No carrier shall use COVID-19 vaccination status of the patient of a provider as a qualification or requirement for entering into a provider contract with the provider or as a basis for terminating the

provider contract with the provider.

C. If the Commission has cause to believe that any provider has engaged in a pattern of potential violations of subdivision B 13, with no corrective action, the Commission may submit information to the Board of Medicine or the Commissioner of Health for action. Prior to such submission, the Commission may provide the provider with an opportunity to cure the alleged violations or provide an explanation as to why the actions in questions were not violations. If any provider has engaged in a pattern of potential violations of subdivision B 13, with no corrective action, the Board of Medicine or the Commissioner of Health may levy a fine or cost recovery upon the provider and take other action as permitted under its authority. Upon completion of its review of any potential violation submitted by the Commission or initiated directly by an enrollee, the Board of Medicine or the Commissioner of Health shall notify the Commission of the results of the review, including where the violation was substantiated, and any enforcement action taken as a result of a finding of a substantiated violation.

D. Without limiting the foregoing, in the processing of any payment of claims for health care services rendered by providers under provider contracts and in performing under its provider contracts, every carrier subject to regulation by this title shall adhere to and comply with the minimum fair business standards required under subsection B, and the Commission shall have the jurisdiction to determine if a carrier has violated the standards set forth in subsection B by failing to include the requisite provisions in its provider contracts and shall have jurisdiction to determine if the carrier has failed to implement the minimum fair business standards set out in subdivisions B 1 and 2 in the performance of its provider contracts.

E. No carrier shall be in violation of this section if its failure to comply with this section is caused in material part by the person submitting the claim or if the carrier's compliance is rendered impossible due to matters beyond the carrier's reasonable control (such as an act of God, insurrection, strike, fire, or power outages) which are not caused in material part by the carrier.

F. Any provider who suffers loss as the result of a carrier's violation of this section or a carrier's breach of any provider contract provision required by this section shall be entitled to initiate an action to recover actual damages. If the trier of fact finds that the violation or breach resulted from a carrier's gross negligence and willful conduct, it may increase damages to an amount not exceeding three times the actual damages sustained. Notwithstanding any other provision of law to the contrary, in addition to any damages awarded, such provider also may be awarded reasonable attorney fees and court costs. Each claim for payment which is paid or processed in violation of this section or with respect to which a violation of this section exists shall constitute a separate violation. The Commission shall not be deemed to be a "trier of fact" for purposes of this subsection.

G. No carrier (or its network, provider panel or intermediary) shall terminate or fail to renew the employment or other contractual relationship with a provider, or any provider contract, or otherwise penalize any provider, for invoking any of the provider's rights under this section or under the provider contract.

H. This section shall apply only to carriers subject to regulation under this title.

I. This section shall apply with respect to provider contracts entered into, amended, extended or renewed on or after July 1, 1999.

J. Pursuant to the authority granted by § 38.2-223, the Commission may promulgate such rules and regulations as it may deem necessary to implement this section.

K. The Commission shall have no jurisdiction to adjudicate individual controversies arising out of this section.

§ 38.2-3438. Definitions.

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

"Allowed amount" means the maximum portion of a billed charge a health carrier will pay, including any applicable cost-sharing requirements, for a covered service or item rendered by a participating provider or by a nonparticipating provider.

"Balance bill" means a bill sent to an enrollee by an out-of-network provider for health care services provided to the enrollee after the provider's billed amount is not fully reimbursed by the carrier, exclusive of applicable cost-sharing requirements.

"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.

"Cost-sharing requirement" means an enrollee's deductible, copayment amount, or coinsurance rate.

"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, regardless of the final diagnosis rendered to a covered person, 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 as of January 1, 2019: (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 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 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; *COVID-19 vaccination status;* 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.

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

"In-network" or "participating" means a provider that has contracted with a carrier or a carrier's contractor or subcontractor to provide health care services to enrollees and be reimbursed by the carrier at a contracted rate as payment in full for the health care services, including applicable cost-sharing requirements.

"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.

"Nonprofit data services organization" means the nonprofit organization with which the Commissioner of Health negotiates and enters into contracts or agreements for the compilation, storage, analysis, and evaluation of data submitted by data suppliers pursuant to § 32.1-276.4.

"Offer to pay" or "payment notification" means a claim that has been adjudicated and paid by a carrier or determined by a carrier to be payable by an enrollee to an out-of-network provider for services described in subsection A of § 38.2-3445.01.

"Open enrollment" means, with respect to individual health insurance coverage, the period of time during which any individual 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.

"Out-of-network" or "nonparticipating" means a provider that has not contracted with a carrier or a carrier's contractor or subcontractor to provide health care services to enrollees.

"Out-of-pocket maximum" or "maximum out-of-pocket" means the maximum amount an enrollee is required to pay in the form of cost-sharing requirements for covered benefits in a plan year, after which the carrier covers the entirety of the allowed amount of covered benefits under the contract of coverage.

"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.

"Preventive services" means (i) evidence-based items or services for which a rating of A or B is in effect in the recommendations of the U.S. Preventive Services Task Force with respect to the individual involved; (ii) immunizations for routine use in children, adolescents, and adults for which a recommendation of the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention is in effect with respect to the individual involved; (iii) evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health

Resources and Services Administration with respect to infants, children, and adolescents; and (iv) evidence-informed preventive care and screenings recommended in comprehensive guidelines supported by the Health Resources and Services Administration with respect to women. For purposes of this definition, a recommendation of 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.

"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.

"Surgical or ancillary services" means professional services, including surgery, anesthesiology, pathology, radiology, or hospitalist services and laboratory services.

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

§ 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.

C. Notwithstanding the provisions of subsection B, in no case shall a health carrier offering a health benefit plan providing group health insurance coverage create conditions for obtaining a premium discount or rebate or other reward for participation in a wellness program that is based on an individual's COVID-19 vaccination status.

§ 40.1-27.5. Discrimination based on COVID-19 vaccination status prohibited.

Notwithstanding any other provision of law, no employer shall require an employee to receive any immunization against COVID-19, and no employer shall discriminate against an employee because of his COVID-19 vaccination status.

§ 44-146.17. (Effective until July 1, 2023) Powers and duties of Governor.

The Governor shall be Director of Emergency Management. He shall take such action from time to time as is necessary for the adequate promotion and coordination of state and local emergency services activities relating to the safety and welfare of the Commonwealth in time of disasters.

The Governor shall have, in addition to his powers hereinafter or elsewhere prescribed by law, the following powers and duties:

(1) To proclaim and publish such rules and regulations and to issue such orders as may, in his judgment, be necessary to accomplish the purposes of this chapter including, but not limited to such measures as are in his judgment required to control, restrict, allocate or regulate the use, sale, production and distribution of food, fuel, clothing and other commodities, materials, goods, services and resources under any state or federal emergency services programs.

He may adopt and implement the Commonwealth of Virginia Emergency Operations Plan, which provides for state-level emergency operations in response to any type of disaster or large-scale emergency affecting Virginia and that provides the needed framework within which more detailed emergency plans and procedures can be developed and maintained by state agencies, local governments and other organizations.

He may direct and compel evacuation of all or part of the populace from any stricken or threatened area if this action is deemed necessary for the preservation of life, implement emergency mitigation, preparedness, response or recovery actions; prescribe routes, modes of transportation and destination in connection with evacuation; and control ingress and egress at an emergency area, including the movement of persons within the area and the occupancy of premises therein.

Executive orders, to include those declaring a state of emergency and directing evacuation, shall have the force and effect of law and the violation thereof shall be punishable as a civil penalty of not more than $500 or as a Class 1 misdemeanor in every case where the executive order declares that its violation shall have such force and effect. Where an executive order declares a violation shall be punishable as a civil penalty, such violation shall be charged by summons and may be executed by a law-enforcement officer when such violation is observed by the officer. The summons used by a law-enforcement officer pursuant to this section shall be, in form, the same as the uniform summons for motor vehicle law violations as prescribed pursuant to § 46.2-388. The proceeds of such civil penalties collected pursuant to this section shall be paid and collected only in lawful money of the United States and paid into the state treasury to the credit of the Literary Fund.

Such executive orders declaring a state of emergency may address exceptional circumstances that exist relating to an order of quarantine or an order of isolation concerning a communicable disease of public health threat that is issued by the State Health Commissioner for an affected area of the Commonwealth pursuant to Article 3.02 (§ 32.1-48.05 et seq.) of Chapter 2 of Title 32.1.

Except as to emergency plans issued to prescribe actions to be taken in the event of disasters and emergencies, no rule, regulation, or order issued under this section shall have any effect beyond June 30 next following the next adjournment of the regular session of the General Assembly but the same or a

similar rule, regulation, or order may thereafter be issued again if not contrary to law.

No rule, regulation, or order issued under this subdivision shall require a person to receive any immunization against COVID-19;

(2) To appoint a State Coordinator of Emergency Management and authorize the appointment or employment of other personnel as is necessary to carry out the provisions of this chapter, and to remove, in his discretion, any and all persons serving hereunder;

(3) To procure supplies and equipment, to institute training and public information programs relative to emergency management and to take other preparatory steps including the partial or full mobilization of emergency management organizations in advance of actual disaster, to insure the furnishing of adequately trained and equipped forces in time of need;

(4) To make such studies and surveys of industries, resources, and facilities in the Commonwealth as may be necessary to ascertain the capabilities of the Commonwealth and to plan for the most efficient emergency use thereof;

(5) On behalf of the Commonwealth to enter into mutual aid arrangements with other states and to coordinate mutual aid plans between political subdivisions of the Commonwealth. After a state of emergency is declared in another state and the Governor receives a written request for assistance from the executive authority of that state, the Governor may authorize the use in the other state of personnel, equipment, supplies, and materials of the Commonwealth, or of a political subdivision, with the consent of the chief executive officer or governing body of the political subdivision;

(6) To delegate any administrative authority vested in him under this chapter, and to provide for the further delegation of any such authority, as needed;

(7) Whenever, in the opinion of the Governor, the safety and welfare of the people of the Commonwealth require the exercise of emergency measures due to a threatened or actual disaster, to declare a state of emergency to exist;

(8) To request a major disaster declaration from the President, thereby certifying the need for federal disaster assistance and ensuring the expenditure of a reasonable amount of funds of the Commonwealth, its local governments, or other agencies for alleviating the damage, loss, hardship, or suffering resulting from the disaster;

(9) To provide incident command system guidelines for state agencies and local emergency response organizations;

(10) Whenever, in the opinion of the Governor or his designee, an employee of a state or local public safety agency responding to a disaster has suffered an extreme personal or family hardship in the affected area, such as the destruction of a personal residence or the existence of living conditions that imperil the health and safety of an immediate family member of the employee, to direct the Comptroller of the Commonwealth to issue warrants not to exceed $2,500 per month, for up to three calendar months, to the employee to assist the employee with the hardship; and

(11) During a disaster caused by a communicable disease of public health threat for which a state of emergency has been declared pursuant to subdivision (7), to establish a program through which the Governor may purchase PPE for private, nongovernmental entities and distribute the PPE to such private, nongovernmental entities. If federal funding is available to establish and fund the program, the Governor, if necessary to comply with any conditions attached to such federal funding, shall be entitled to seek reimbursement for such purchases from the private, nongovernmental entities and may establish and charge fees to recover the cost of administering the program, including the cost of procuring and distributing the PPE. However, if federal funding is not available to establish and fund the program, the Governor shall, prior to making such purchases, receive a contract for payment for purchase from the private nongovernmental entities for the full cost of procuring and distributing the PPE, which shall include any amortized costs of administering the program. Any purchase made by the Governor pursuant to this subdivision shall be exempt from the provisions of the Virginia Public Procurement Act (§ 2.2-4300 et seq.), except the Governor shall be encouraged to comply with the provisions of § 2.2-4310 when possible. The Governor shall also provide for competition where practicable and include a written statement regarding the basis for awarding any contract. Prior to implementing such a program, the Department of Emergency Management shall consult with and survey private, nongovernmental entities in order to assess demand for participation in the program as well as the quantity and types of personal protective equipment such entities would like to procure.

As used in this subdivision, "personal protective equipment" or "PPE" means equipment or supplies worn or employed to minimize exposure to hazards that cause serious workplace injuries and illnesses and may include items such as gloves, safety glasses and shoes, earplugs or muffs, hard hats, respirators, coveralls, vests, full body suits, hand sanitizer, plastic shields, or testing for the communicable disease of public health threat.

§ 44-146.17. (Effective July 1, 2023) Powers and duties of Governor.

The Governor shall be Director of Emergency Management. He shall take such action from time to time as is necessary for the adequate promotion and coordination of state and local emergency services

activities relating to the safety and welfare of the Commonwealth in time of disasters.

The Governor shall have, in addition to his powers hereinafter or elsewhere prescribed by law, the following powers and duties:

(1) To proclaim and publish such rules and regulations and to issue such orders as may, in his judgment, be necessary to accomplish the purposes of this chapter including, but not limited to such measures as are in his judgment required to control, restrict, allocate or regulate the use, sale, production and distribution of food, fuel, clothing and other commodities, materials, goods, services and resources under any state or federal emergency services programs.

He may adopt and implement the Commonwealth of Virginia Emergency Operations Plan, which provides for state-level emergency operations in response to any type of disaster or large-scale emergency affecting Virginia and that provides the needed framework within which more detailed emergency plans and procedures can be developed and maintained by state agencies, local governments and other organizations.

He may direct and compel evacuation of all or part of the populace from any stricken or threatened area if this action is deemed necessary for the preservation of life, implement emergency mitigation, preparedness, response or recovery actions; prescribe routes, modes of transportation and destination in connection with evacuation; and control ingress and egress at an emergency area, including the movement of persons within the area and the occupancy of premises therein.

Executive orders, to include those declaring a state of emergency and directing evacuation, shall have the force and effect of law and the violation thereof shall be punishable as a Class 1 misdemeanor in every case where the executive order declares that its violation shall have such force and effect.

Such executive orders declaring a state of emergency may address exceptional circumstances that exist relating to an order of quarantine or an order of isolation concerning a communicable disease of public health threat that is issued by the State Health Commissioner for an affected area of the Commonwealth pursuant to Article 3.02 (§ 32.1-48.05 et seq.) of Chapter 2 of Title 32.1.

Except as to emergency plans issued to prescribe actions to be taken in the event of disasters and emergencies, no rule, regulation, or order issued under this section shall have any effect beyond June 30 next following the next adjournment of the regular session of the General Assembly but the same or a similar rule, regulation, or order may thereafter be issued again if not contrary to law.

No rule, regulation, or order issued under this subdivision shall require a person to receive any immunization against COVID-19;

(2) To appoint a State Coordinator of Emergency Management and authorize the appointment or employment of other personnel as is necessary to carry out the provisions of this chapter, and to remove, in his discretion, any and all persons serving hereunder;

(3) To procure supplies and equipment, to institute training and public information programs relative to emergency management and to take other preparatory steps including the partial or full mobilization of emergency management organizations in advance of actual disaster, to insure the furnishing of adequately trained and equipped forces in time of need;

(4) To make such studies and surveys of industries, resources, and facilities in the Commonwealth as may be necessary to ascertain the capabilities of the Commonwealth and to plan for the most efficient emergency use thereof;

(5) On behalf of the Commonwealth to enter into mutual aid arrangements with other states and to coordinate mutual aid plans between political subdivisions of the Commonwealth. After a state of emergency is declared in another state and the Governor receives a written request for assistance from the executive authority of that state, the Governor may authorize the use in the other state of personnel, equipment, supplies, and materials of the Commonwealth, or of a political subdivision, with the consent of the chief executive officer or governing body of the political subdivision;

(6) To delegate any administrative authority vested in him under this chapter, and to provide for the further delegation of any such authority, as needed;

(7) Whenever, in the opinion of the Governor, the safety and welfare of the people of the Commonwealth require the exercise of emergency measures due to a threatened or actual disaster, to declare a state of emergency to exist;

(8) To request a major disaster declaration from the President, thereby certifying the need for federal disaster assistance and ensuring the expenditure of a reasonable amount of funds of the Commonwealth, its local governments, or other agencies for alleviating the damage, loss, hardship, or suffering resulting from the disaster;

(9) To provide incident command system guidelines for state agencies and local emergency response organizations;

(10) Whenever, in the opinion of the Governor or his designee, an employee of a state or local public safety agency responding to a disaster has suffered an extreme personal or family hardship in the affected area, such as the destruction of a personal residence or the existence of living conditions that

imperil the health and safety of an immediate family member of the employee, to direct the Comptroller of the Commonwealth to issue warrants not to exceed $2,500 per month, for up to three calendar months, to the employee to assist the employee with the hardship; and

(11) During a disaster caused by a communicable disease of public health threat for which a state of emergency has been declared pursuant to subdivision (7), to establish a program through which the Governor may purchase PPE for private, nongovernmental entities and distribute the PPE to such private, nongovernmental entities. If federal funding is available to establish and fund the program, the Governor, if necessary to comply with any conditions attached to such federal funding, shall be entitled to seek reimbursement for such purchases from the private, nongovernmental entities and may establish and charge fees to recover the cost of administering the program, including the cost of procuring and distributing the PPE. However, if federal funding is not available to establish and fund the program, the Governor shall, prior to making such purchases, receive a contract for payment for purchase from the private nongovernmental entities for the full cost of procuring and distributing the PPE, which shall include any amortized costs of administering the program. Any purchase made by the Governor pursuant to this subdivision shall be exempt from the provisions of the Virginia Public Procurement Act (§ 2.2-4300 et seq.), except the Governor shall be encouraged to comply with the provisions of § 2.2-4310 when possible. The Governor shall also provide for competition where practicable and include a written statement regarding the basis for awarding any contract. Prior to implementing such a program, the Department of Emergency Management shall consult with and survey private, nongovernmental entities in order to assess demand for participation in the program as well as the quantity and types of personal protective equipment such entities would like to procure.

As used in this subdivision, "personal protective equipment" or "PPE" means equipment or supplies worn or employed to minimize exposure to hazards that cause serious workplace injuries and illnesses and may include items such as gloves, safety glasses and shoes, earplugs or muffs, hard hats, respirators, coveralls, vests, full body suits, hand sanitizer, plastic shields, or testing for the communicable disease of public health threat.

§ 46.2-333.2. Discrimination based on COVID-19 status prohibited.

A. The Department shall not deny the issuance of a driver's license or other document issued under this chapter to any individual solely because of such individual's COVID-19 vaccination status.

B. The provisions of this section shall not apply to the issuance of a commercial driver's license by the Department.

§ 54.1-2409.6. Boards not authorized to require vaccinations.

A. Notwithstanding any other provision of law, neither the Board nor any health regulatory board included in the Department shall require any person to be immunized against COVID-19.

B. No person shall be denied a license, registration, certification, multisite licensure privilege, or other privilege solely because of his COVID-19 vaccination status.

C. No person licensed by any health regulatory board included in the Department shall deny any person services solely because of his COVID-19 vaccination status.

§ 63.2-221.1. Board not authorized to require vaccination.

A. Notwithstanding any other provision of law, the Board shall not require any person to be immunized against COVID-19.

B. No person licensed by the Department shall deny any person services solely because of his COVID-19 vaccination status.

§ 63.2-603. Eligibility for TANF; childhood immunizations.

An applicant for TANF shall provide verification that all eligible children not enrolled in school, a licensed family day home as defined in § 22.1-289.02, or a licensed child day center as defined in § 22.1-289.02, have received immunizations in accordance with § 32.1-46, *except that no child shall be required to have received any COVID-19 immunization*. However, if an eligible child has not received immunizations in accordance with § 32.1-46, verification shall be provided at the next scheduled redetermination of eligibility for TANF after initial eligibility is granted that the child has received at least one dose of each of the immunizations required by § 32.1-46 as appropriate for the child's age and that the child's physician or the local health department has developed a plan for completing the immunizations. Verification of compliance with the plan for completing the immunizations shall be presented at subsequent redeterminations of eligibility for TANF.

If necessary, the local department shall provide assistance to the TANF recipient in obtaining verification from immunization providers. No sanction may be imposed until the reason for the failure to comply with the immunization requirement has been identified and any barriers to accessing immunizations have been removed.

Failure by the recipient to provide the required verification of immunizations shall result in a reduction in the amount of monthly assistance received from the TANF program until the required verification is provided. The reduction shall be $50 for the first child and $25 for each additional child for whom verification is not provided.

Any person who becomes ineligible for TANF payments as a result of this provision shall nonetheless be considered a TANF recipient for all other purposes.

§ 65.2-402.1. Presumption as to death or disability from infectious disease.

A. Hepatitis, meningococcal meningitis, tuberculosis or HIV causing the death of, or any health condition or impairment resulting in total or partial disability of, any (i) salaried or volunteer firefighter, or salaried or volunteer emergency medical services personnel; (ii) member of the State Police Officers' Retirement System; (iii) member of county, city, or town police departments; (iv) sheriff or deputy sheriff; (v) Department of Emergency Management hazardous materials officer; (vi) city sergeant or deputy city sergeant of the City of Richmond; (vii) Virginia Marine Police officer; (viii) conservation police officer who is a full-time sworn member of the enforcement division of the Department of Wildlife Resources; (ix) Capitol Police officer; (x) special agent of the Virginia Alcoholic Beverage Control Authority appointed under the provisions of Chapter 1 (§ 4.1-100 et seq.) of Title 4.1; (xi) for such period that the Metropolitan Washington Airports Authority voluntarily subjects itself to the provisions of this chapter as provided in § 65.2-305, officer of the police force established and maintained by the Metropolitan Washington Airports Authority; (xii) officer of the police force established and maintained by the Norfolk Airport Authority; (xiii) conservation officer of the Department of Conservation and Recreation commissioned pursuant to § 10.1-115; (xiv) sworn officer of the police force established and maintained by the Virginia Port Authority; (xv) campus police officer appointed under Article 3 (§ 23.1-809 et seq.) of Chapter 8 of Title 23.1 and employed by any public institution of higher education; (xvi) correctional officer as defined in § 53.1-1; or (xvii) full-time sworn member of the enforcement division of the Department of Motor Vehicles who has a documented occupational exposure to blood or body fluids shall be presumed to be occupational diseases, suffered in the line of government duty, that are covered by this title unless such presumption is overcome by a preponderance of competent evidence to the contrary. For purposes of this subsection, an occupational exposure occurring on or after July 1, 2002, shall be deemed "documented" if the person covered under this subsection gave notice, written or otherwise, of the occupational exposure to his employer, and an occupational exposure occurring prior to July 1, 2002, shall be deemed "documented" without regard to whether the person gave notice, written or otherwise, of the occupational exposure to his employer. For any correctional officer as defined in § 53.1-1 or full-time sworn member of the enforcement division of the Department of Motor Vehicles, the presumption shall not apply if such individual was diagnosed with hepatitis, meningococcal meningitis, or HIV before July 1, 2020.

B. 1. COVID-19 causing the death of, or any health condition or impairment resulting in total or partial disability of, any health care provider, as defined in § 8.01-581.1, who as part of the provider's employment is directly involved in diagnosing or treating persons known or suspected to have COVID-19, shall be presumed to be an occupational disease that is covered by this title unless such presumptions are overcome by a preponderance of competent evidence to the contrary. For the purposes of this section, the COVID-19 virus shall be established by a positive diagnostic test for COVID-19 and signs and symptoms of COVID-19 that require medical treatment, as described in subdivision ~~F~~ *E* 2.

2. COVID-19 causing the death of, or any health condition or impairment resulting in total or partial disability of, any (i) firefighter, as defined in § 65.2-102; (ii) law-enforcement officer, as defined in § 9.1-101; (iii) correctional officer, as defined in § 53.1-1; or (iv) regional jail officer shall be presumed to be an occupational disease, suffered in the line of duty, as applicable, that is covered by this title unless such presumption is overcome by a preponderance of competent evidence to the contrary. For the purposes of this section, the COVID-19 virus shall be established by a positive diagnostic test for COVID-19, an incubation period consistent with COVID-19, and signs and symptoms of COVID-19 that require medical treatment.

C. As used in this section:

"Blood or body fluids" means blood and body fluids containing visible blood and other body fluids to which universal precautions for prevention of occupational transmission of blood-borne pathogens, as established by the Centers for Disease Control, apply. For purposes of potential transmission of hepatitis, meningococcal meningitis, tuberculosis, or HIV the term "blood or body fluids" includes respiratory, salivary, and sinus fluids, including droplets, sputum, saliva, mucous, and any other fluid through which infectious airborne or blood-borne organisms can be transmitted between persons.

"Hepatitis" means hepatitis A, hepatitis B, hepatitis non-A, hepatitis non-B, hepatitis C, or any other strain of hepatitis generally recognized by the medical community.

"HIV" means the medically recognized retrovirus known as human immunodeficiency virus, type I or type II, causing immunodeficiency syndrome.

"Occupational exposure," in the case of hepatitis, meningococcal meningitis, tuberculosis or HIV, means an exposure that occurs during the performance of job duties that places a covered employee at risk of infection.

D. Persons covered under this section who test positive for exposure to the enumerated occupational

diseases, but have not yet incurred the requisite total or partial disability, shall otherwise be entitled to make a claim for medical benefits pursuant to § 65.2-603, including entitlement to an annual medical examination to measure the progress of the condition, if any, and any other medical treatment, prophylactic or otherwise.

E. ~~1. Whenever any standard, medically-recognized vaccine or other form of immunization or prophylaxis exists for the prevention of a communicable disease for which a presumption is established under this section, if medically indicated by the given circumstances pursuant to immunization policies established by the Advisory Committee on Immunization Practices of the United States Public Health Service, a person subject to the provisions of this section may be required by such person's employer to undergo the immunization or prophylaxis unless the person's physician determines in writing that the immunization or prophylaxis would pose a significant risk to the person's health. Absent such written declaration, failure or refusal by a person subject to the provisions of this section to undergo such immunization or prophylaxis shall disqualify the person from any presumption established by this section.~~

~~2. The presumptions described in subdivision B 1 shall not apply to any person offered by such person's employer a vaccine for the prevention of COVID-19 with an Emergency Use Authorization issued by the U.S. Food and Drug Administration, unless the person is immunized or the person's physician determines in writing that the immunization would pose a significant risk to the person's health. Absent such written declaration, failure or refusal by a person subject to the provisions of this section to undergo such immunization shall disqualify the person from the presumptions described in subdivision B 1.~~

~~F.~~ 1. The presumptions described in subsection A shall only apply if persons entitled to invoke them have, if requested by the appointing authority or governing body employing them, undergone preemployment physical examinations that (i) were conducted prior to the making of any claims under this title that rely on such presumptions; (ii) were performed by physicians whose qualifications are as prescribed by the appointing authority or governing body employing such persons; (iii) included such appropriate laboratory and other diagnostic studies as the appointing authorities or governing bodies may have prescribed; and (iv) found such persons free of hepatitis, meningococcal meningitis, tuberculosis or HIV at the time of such examinations. The presumptions described in subsection A shall not be effective until six months following such examinations, unless such persons entitled to invoke such presumption can demonstrate a documented exposure during the six-month period.

2. The presumptions described in subdivision B 1 shall apply to any person entitled to invoke them for any death or disability occurring on or after March 12, 2020, caused by infection from the COVID-19 virus, provided that for any such death or disability that occurred on or after March 12, 2020, and prior to December 31, 2021, and;

a. Prior to July 1, 2020, the claimant received a positive diagnosis of COVID-19 from a licensed physician, nurse practitioner, or physician assistant after either (i) a presumptive positive test or a laboratory-confirmed test for COVID-19 and presenting with signs and symptoms of COVID-19 that required medical treatment, or (ii) presenting with signs and symptoms of COVID-19 that required medical treatment absent a presumptive positive test or a laboratory-confirmed test for COVID-19; or

b. On or after July 1, 2020, and prior to December 31, 2021, the claimant received a positive diagnosis of COVID-19 from a licensed physician, nurse practitioner, or physician assistant after a presumptive positive test or a laboratory-confirmed test for COVID-19 and presented with signs and symptoms of COVID-19 that required medical treatment.

3. The presumptions described in subdivision B 2 shall apply to any person entitled to invoke them for any death or disability occurring on or after July 1, 2020, caused by infection from the COVID-19 virus, provided that for any such death or disability that occurred on or after July 1, 2020, and prior to December 31, 2021, the claimant received a diagnosis of COVID-19 from a licensed physician, after either a presumptive positive test or a laboratory confirmed test for COVID-19, and presented with signs and symptoms of COVID-19 that required medical treatment.

~~G.~~ *F.* Persons making claims under this title who rely on such presumption shall, upon the request of appointing authorities or governing bodies employing such persons, submit to physical examinations (i) conducted by physicians selected by such appointing authorities or governing bodies or their representatives and (ii) consisting of such tests and studies as may reasonably be required by such physicians. However, a qualified physician, selected and compensated by the claimant, may, at the election of such claimant, be present at such examination.